TESTING AN INTEGRATED MODEL OF RACISM-RELATED STRESS AMONG BLACK AMERICANS

BY

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DISSERTATION

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Abstract

The purpose of this study was to empirically test an integrated model of racism-related stress that incorporated aspects of two existing models of racism-related stress: the Biopsychosocial Model of Perceived Racism (BMPR; Clark, Anderson, Clark, & Williams, 1999) and the Model of Racism-related Stress and Well-being (MRSW; Harrell, 2000). Specifically, this study examined the influence of antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization on racism-related stress and the subsequent influence this stress had on health outcomes (i.e., psychological distress and anger). The study also explored if cultural and race variables (i.e., cultural coping and racial attitudes) moderated this relation among Black Americans. A community sample of 185 self-identified Black Americans completed a paper-and-pencil survey. Findings provided partial support for the integrated model. Specifically, contextual factors were related to racism-related stress and the relation between racism-related stress and psychological outcomes was moderated by cultural coping, although not in the expected direction. Specifically, men, individuals in neighborhoods with fewer Black residents, and individuals who received messages about race and racism (i.e., racial socialization) reported greater levels of racism-related stress. Additionally, collective coping was a moderator between racism-related stress and psychological distress. Although, on average, the use of greater collective coping was related to increased psychological distress, it appears that the level of racism-related stress individuals reported mattered in understanding this relation. For participants who reported fewer experiences with racism-related stress incidents and who reported lower levels of collectivistic coping showed the lowest levels of psychological distress. For those who reported both greater experiences with racism-related stress, there were no real differences between high or low collective coping efforts. Ritual coping also moderated

the relation between racism-related stress and psychological outcomes (i.e., psychological distress and anger), such that individuals who reported higher levels of racism-related stress and used greater ritual coping strategies to deal with the stress were more likely to report greater levels of psychological distress and anger. Implications and future directions are discussed.

I stand on the shoulders of my ancestors, thank you for holding me up

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Chapter One

Introduction

Racism continues to be a prevalent problem in society for racial minorities. In 2008, over half (51.3%) of hate crimes were racially motivated, and of these nearly three-quarters (72.6%) were motivated by anti-Black sentiments (Federal Bureau of Investigation, 2009). Research has also found that the overwhelming majority of Black American adults report one experience with racial discrimination in their lifetime (Kessler, Mickelson, & Williams, 1999). In addition to these types of individual experiences of racism, there are several health disparities between Black and White Americans that reflect structural racism, such as Black Americans having higher death rates for most of the fifteen leading causes of death (e.g., cancer, heart disease, diabetes, hypertension) (Kung, Hoyert, Xu, & Murphy, 2008), even when SES is controlled (Pamuk, Makuk, Heck, & Reuben, 1998; Williams & Mohammed, 2009). In terms of mental health, researchers suggest racism negatively influences racial minorities psychological well-being in three ways: "(a) racial stereotypes and negative images can be internalized, denigrating individuals' self-worth and adversely affecting their social and psycho-logical functioning; (b) racism and discrimination by societal institutions have resulted in minorities' lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health; and (c) racism and discrimination are stressful events that can directly lead to psychological distress and physiological changes affecting mental health" (Department of Health and Human Services, 2001, p. 39).

In other words, research has found that racism is a distinct source of chronic (Harrell, 2000; Pieterse & Carter, 2007; Utsey, Ponterotto, Reynolds, & Cancelli, 2000) and daily stress (Sellers & Shelton, 2003). Given the prevalence of racism and the resulting stress from racism,

social scientists have begun to examine the influence of racism-related stress on the health of racial minorities. Racism-related stress refers to an individual's subjective experience of prejudice or discrimination (Clark et al., 1999). Systematic reviews of the empirical research on racism-related stress and health outcomes suggest that the strongest and most consistent finding is that racism-related stress can lead to negative mental health (Paradies, 2006; Pascoe & Richman, 2009) and physical health outcomes (Pascoe & Richman, 2009). For example, studies have found a significant positive association between racism-related stress and health related behaviors such as alcohol use, substance use, and cigarette smoking (Guthrie, Young, Williams, Boyd, & Kintner, 2002; Landrine & Klonoff, 1996; Landrine & Klonoff, 2000. Racism-related stress has also been found to be related to several mental health outcomes including trauma (Carter, 2007), poor quality of life (Noh & Kaspar, 2003; Utsey & Payne, 2000), decreased life satisfaction (Jackson et al., 1996; Williams, Yu, Jackson, & Anderson, 1997), psychological well-being (Schulz et al., 2000; Williams et al., 1997), depression (McNeilly et al., 1996; Thompson, 1996), and psychological distress (Broman, Mavaddat, & Hsu, 2000; Carter, Forsyth, Mazzula, & Williams, 2005; Klonoff, Landrine, & Ullman, 1999; Landrine & Klonoff, 1996; Ren, Amick, & Williams, 1999; Williams, 2000) in theoretically expected directions.

Given that racism-related stress can have a detrimental influence on the health of racial minorities, research should continue to explore this relation to inform prevention and interventions. It is particularly important to explore the specific factors that affect racism-related stress as well as factors that can lessen the negative effects of racism-related stress on health outcomes. The purpose of this study is to empirically test an integrated model of racism-related stress to further understand the influence of racism-related stress on Black Americans' psychological health. Below, I outline the proposed integrated model of racism-related stress that

incorporates aspects of both models and that is tested in this study. Specifically, I outline the influence of antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization on racism-related stress and also the role of cultural and race variables, particularly cultural coping and racial attitudes (i.e., racial color-blind ideology) in moderating the relation between racism-related stress and health outcomes.

Integrated Model of Racism-related Stress

In this study, I incorporate aspects of two common models of racism-related stress [i.e., the Biopsychosocial Model of Perceived Racism (BMPR; Clark et al., 1999) and the Model of Racism-related Stress and Well-being (MRSW; Harrell, 2000)] into the integrated model of racism-related stress. The model is outlined in Figure 1. The integrated model is grounded in the interactional model of stress developed by Lazarus and Folkman (1984). From this perspective, stress is "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding (his or her) resources and endangering (his or her) well-being" (Lazarus & Folkman, p. 19). The process of understanding stress consists of three parts: (a) a precipitating stressful event, (b) an appraisal process, followed by (c) coping strategies. The integrated model synthesizes tenets the BMPR and MRSW and draws on the conceptual strengths of both models to account for factors that may not have been fully explored in the other. Specifically, the integrated model of racism-related stress asserts that (a) antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization are related to racism-related stress and (b) racism-related stress leads to negative health outcomes (i.e., psychological distress and anger) because it is moderated by cultural and race variables (i.e., racial attitudes and racism-related coping). Research on aspects of the integrated model of

racism-related stress has either been scarce or mixed. As such, there are several gaps in the racism-related stress literature. For example, research on antecedent variables is mixed. Some studies have found that Black Americans who are older (Peters, 2004; Steffen, McNeilly, Anderson, & Sherwood, 2003), have a higher income (Clark et al., 1999; Kennedy, Kawachi, Lochner, Jones, & Prothrow-Stith, 1997), are more formally educated (Broman et al., 2000; Gary, 1995; Sigelman & Welch, 1991), have professional jobs (Krieger, Sidney, & Coakley, 1998), and are men (Broman et al., 2000; Clark, 2004; Fischer & Shaw, 1999; McCord & Ensminger, 1997; Sellers & Shelton, 2003; Utsey, Payne, Jackson, & Jones, 2002) report higher levels of racism-related stress. However, other studies have found relations in the opposite direction (Broman et al., 2000; Forman, Williams, & Jackson, 1997; Gary, 1995; Gibbons, Gerrand, Cleveland, Wills, & Brody, 2004; Kennedy et al., 1997; Sigelman & Welch, 1991; Stancil, Hertz-Picciotto, Schramm, & Watt-Morse, 2000). There are also studies that have not found a relation between antecedent variables and racism-related stress (Branscombe, Schmitt, & Harvey, 1999; Broman et al., 2000; Clark, 2004; Fisher, Wallace, & Fenton, 2000; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003; Swim, Hyers, Cohen, Fitzgerald, & Bylsma, 2003). Additionally, few empirical studies have examined the association between racism-related stress and the racial composition of the contexts in which a person lives and functions. The preceding equivocal findings may be explained by the lack of variability in the samples (e.g., mostly college students), inconsistencies in the way the antecedents were measured (e.g., SES measured by income, education, class background), and differences in the context where racism was perceived to occur (e.g., employment, medical care, and being threatened and harassed). There is not a clear pattern in the findings in terms of sample, measures, direction of the results, etc., thus it is difficult to make additional observations.

Research has also found that racial socialization is associated with coping with racism-related stress among Black adolescents (Hughes, Rodriguez, Smith, Johnson, Stevenson, & Spicer, 2006). Additionally, the racial composition of individuals' neighborhoods predicted racial socialization, such that preparation for bias (i.e., promoting awareness of discrimination) racial socialization messages were greater in integrated neighborhoods than in mostly Black or White neighborhoods (Hughes et al., 2006). However, most of the research on racial socialization has focused on youth. Studies with Black adults have found that racial socialization aids Black college students with adjusting academically (Anglin & Wade, 2007), that it is a buffer against the negative impact of racism-related stress (Fischer & Shaw, 1999), and that greater messages about cultural ways to cope with racism can increase racism-related stress (Bynum, Burton, & Best, 2007). It is important to continue to examine racial socialization and how it influences racism-related stress because it has been linked to negative health outcomes.

In the integrated model of racism-related stress, I propose racism-related stress will be linked to individuals' health. In their meta-analysis Pascoe and Richman (2009) found racism-related stress has a negative effect on individuals' health, including their psychological well-being. In this study, I explore two dimensions of psychological distress: general distress and anger. Research on the relation between racism-related stress and psychological distress has been inconsistent; however, a review of literature by Paradies (2006) suggested the differences in findings may be related to poor conceptualizations of racism-related stress. Among Black Americans, studies have found that racism-related stress is significantly positively related to psychological distress (Brown et al., 2000; Bynum et al., 2007; Carter et al., 2005; Hendryx & Ahern, 1997; Hope & Klonoff, 1996; Jackson et al., 1996; Pieterse & Carter, 2007; Ren et al., 1999; Taylor & Turner, 2002; Williams et al., 1997) and that it is a stronger predictor of

psychological distress (Brown, Keith, Jackson, & Gary, 2003; Franklin-Jackson & Carter, 2007; Utsey & Payne, 2000), even more so than general stressful life events (Utsey, Giesbrecht, Hook, & Stanard, 2007). In sum, these studies suggest that psychological distress is an important mental health outcome to consider (Pascoe & Richman, 2009; Paradies, 2006).

Anger is a common psychosocial experience that individuals feel after an experience of racism (Bullock & Houston, 1987). It is not surprising then that racism-related stress has been significantly related to increased levels of anger (Combs et al., 2006; Wong, Eccles, & Sameroff, 2003), anger inhibition (i.e., anger remains contained due to a fear of expressing it) (Steffen et al., 2003), and also the ways people handle anger (i.e., act like nothing happened, keeping it to themselves) (Krieger et al., 1998). Furthermore, there is evidence that anger can negatively affect an individual's health, as it has been significantly related to high blood pressure (Clark, 2006; Ewart & Kolodner, 1994) as well as cardiac and vascular functioning (Ewart & Kolodner, 1994; Hogan & Linden, 2004; Schum, Jorgensen, Verhaeghen, Sauro, & Thibodeau, 2003).

There is limited research on the influence of cultural coping styles on the link between racism-related stress and health outcomes; however, over the past decade research on cultural and race coping styles have increased (e.g., development of the Africultural Coping Systems Inventory; Utsey, Adams, & Bolden, 2000). Some studies have found that Black Americans cope with racism-related stress by using cultural coping strategies such as disidentification, devaluing, and discounting when they feel they are being judged (Crocker & Major, 1989). Empirical studies suggest that there is a direct link between the way Black Americans cope with stress and negative outcomes. They also suggest that coping can moderate the relation between racism-related stress and negative outcomes. Specifically, the studies suggest cultural forms of coping

may be more effective in mitigating the harmful effects of racism-related stress (Constantine, Wilton, Gainor, & Lewis, 2002; Utsey et al., 2007).

Finally, in the integrated model of racism-related stress, I propose that racial attitudes, particularly color-blind racial ideology, may moderate the relation between racism-related stress and health yet little empirical research has been done in this area. Color-blind racial ideology refers to the denial, distortion, and minimization of racism; and research suggests that Black Americans who have a limited awareness of institutional racism received fewer messages while they were growing up to protect them against racism and racial barriers (Barr & Neville, 2008). This may lead to negative consequences such as assimilation (i.e., valuing individuality instead of collectivism) (Bonilla-Silva, 2003) and internalized oppression (Bonilla-Silva, 2003; Neville, Coleman, Falconer, & Holmes, 2005). These findings suggest CBRI may be a moderator of health outcomes, particularly when individuals deny the existence of racism. This denial (i.e., as an indicator of internalized oppression) could in turn affect an individual's health.

Research Questions

There is growing evidence documenting the relations between racism-related stress and negative mental health among Black Americans; however, research on aspects of the integrated model of racism-related stress have either been scarce or mixed. This study seeks to provide empirical data to help fill the gaps in the literature by empirically testing the integrated model of racism-related stress shown in Figure 1.

The specific research questions and hypotheses are:

1. Are antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization related to self-reported racism-related stress?

- Although the literature on sociodemographic factors has been equivocal, I hypothesize men, older individuals, people from lower SES backgrounds, and people from more racially diverse contexts will report greater levels of racism-related stress because studies have found these relations more consistently. I also hypothesize individuals who report greater levels of racial socialization will report greater levels of racism-related stress similar to previous research.

2. Is racism-related stress related to psychological outcomes?

    - On the basis of previous empirical research and theoretical assertions outlined in the BMPR and MRSW, I hypothesize racism-related stress will be significantly positively related to psychological distress and anger such that individuals who report more experiences of racism will report more psychological distress and anger.

3. Do cultural coping and racism-related attitudes (i.e., CBRI) moderate the relation between racism-related stress and psychological outcomes?

    - On the basis of BMPR and MRSW models, I hypothesize cultural coping and racism-related attitudes will moderate the relation between racism-related stress and negative health outcomes. Specifically, the use of more active cultural coping strategies and lower levels of CBRI will buffer the negative impact of racism because of the increased awareness of systematic discrimination. However, individuals who report higher levels of CBRI and fewer coping strategies may be at risk of internalizing discrimination because they minimize systemic problems, which in turn could lead to negative health outcomes.

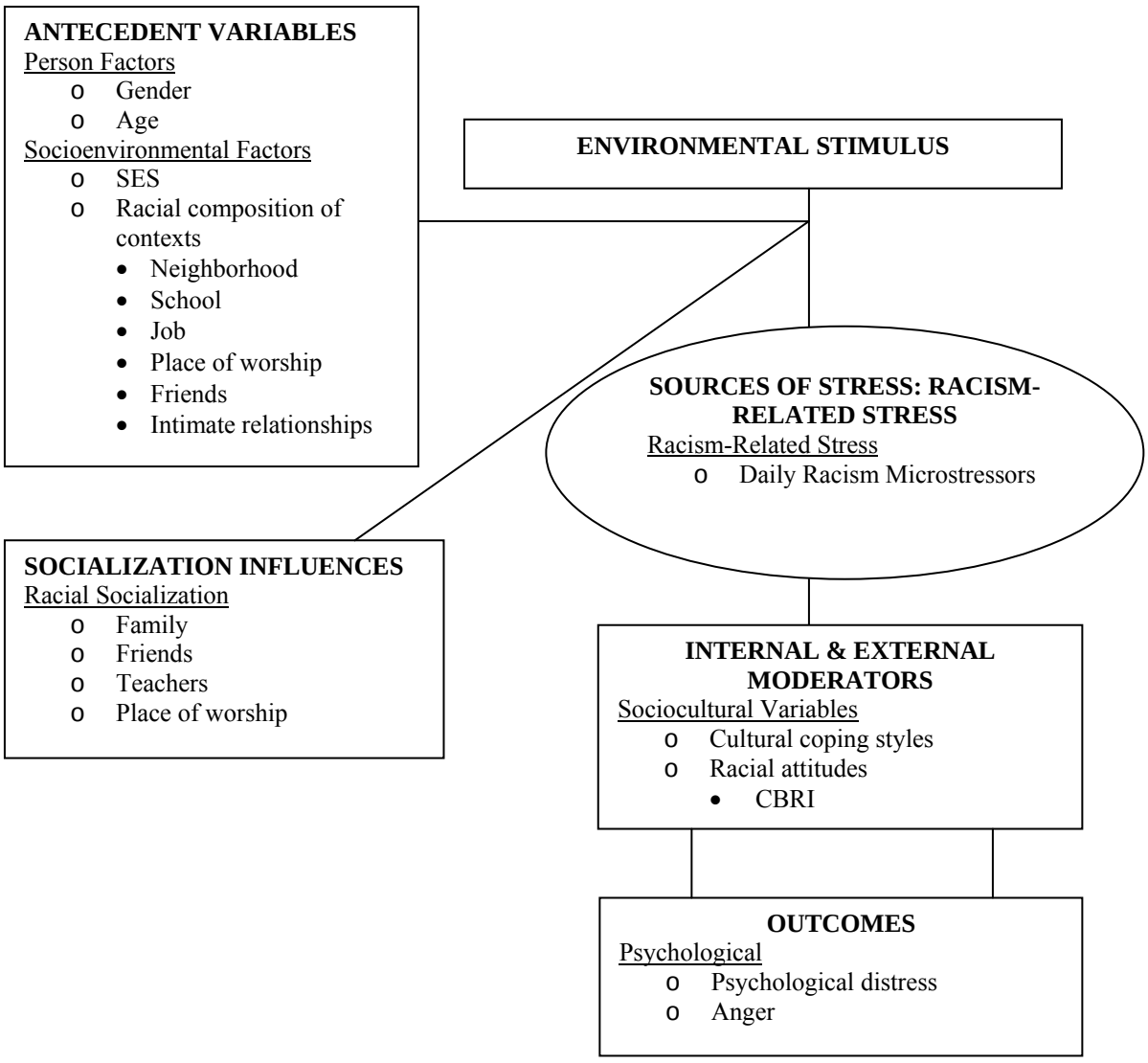

Figure 1. Proposed Integrated Model of Racism-related Stress.

Chapter Two

Literature Review

Research consistently finds a direct association between racism-related stress and psychological health among Black Americans. Although conceptual models have been developed to further understand this relation, most studies are atheoretical. In this literature review, I discuss two models of racism-related stress and propose an integrated model of racism-related stress. I outline the tenets of the integrated model of racism-related stress, specifically, how antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization influence racism-related stress. I include a discussion about the mental health correlates of racism-related stress. Finally, I outline the cultural and race factors (i.e., racism-related coping and CBRI) that might moderate this relation.

Models of Racism-related Stress

The integrated model of racism-related stress incorporates aspects of the Biopsychosocial Model of Racism-related Stress (BMPR; Clark et al., 1999) and the Model of Racism-related Stress and Well-being (MRSW; Harrell, 2000). I selected these two models because they have been consistently referenced in the literature and both are grounded in the interactional model of stress developed by Lazarus and Folkman (1984). According to the BMPR model as shown in Figure 2, an individual's perceptions of environmental stimulus as being a racial stressor can be influenced by several factors, including: (a) constitutional factors (e.g., occupational status, personal income, skin tone), (b) sociodemographic factors (e.g., socioeconomic status, age), and (c) psychological/behavioral factors (e.g., self-esteem, anger, neuroticism). Due to subjective interpretations, an individual may perceive this environmental stimulus as either a racial stressor

or he or she may not interpret the stimulus as a stressor at all. Racism-related stress can in turn be related to health outcomes. This link between racism-related stress and negative health outcomes can be moderated by a number of factors including coping responses. For example, how an individual copes with stress may influence the psychological/physiological stress responses the individual experiences which in turn can influence the individual's health.

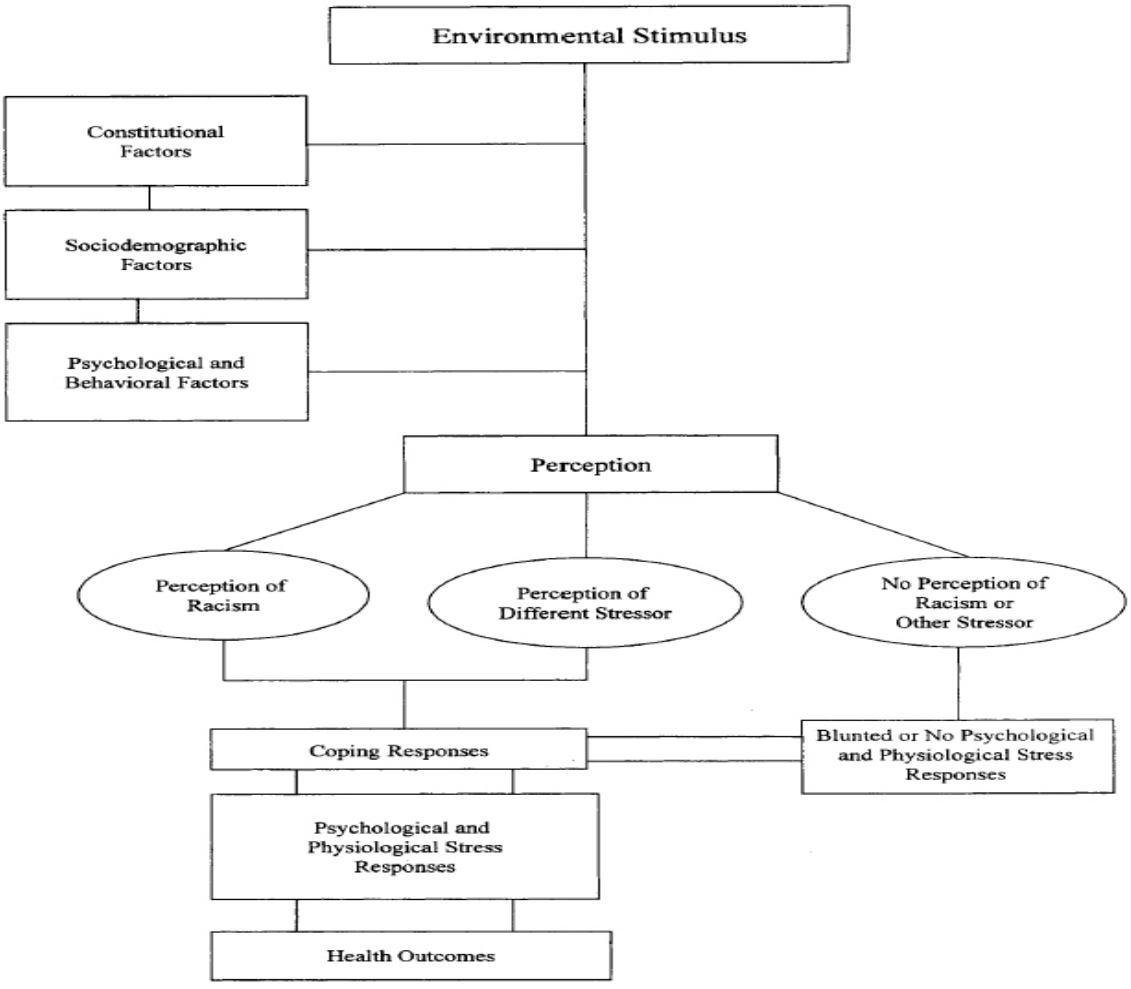

Figure 2. Biopsychosocial Model of Racism-related Stress (BMPR) (Clark et al., 1999).

Harrell's (2000) model of racism-related stress is another often cited work in the literature. As shown in Figure 3, an individual's perceptions of an environmental stimulus as being a racial stressor can be influenced by two types of factors: (a) antecedent variables and (b) familial and socialization influences. The variables encompassed under antecedent variables are

person (e.g., race/ethnicity, gender, age, language) and socioenvironmental factors (e.g., socioeconomic status, racial composition of contexts). The variables encompassed under familial and socialization influences are family characteristics/dynamics (e.g., family structure and roles) and racial socialization (e.g., family, community, institutional). Individuals can interpret the stress as coming from three types of sources: (a) racism-related stress (e.g., daily racism microstressors, racism-related life events), (b) other status-related stress (e.g., sexism, heterosexism, classism), and (c) generic stressors (e.g., role strain, multiple roles, role conflict).

I. ANTECEDENT VARIABLES
- Person Factors
  - Race/ethnicity, gender, age, language, physical characteristics
- Socioenvironmental Factors
  - Current sociopolitical context, regional/geographic location, socioeconomic status (SES), racial composition of contexts

II. FAMILIAL AND SOCIALIZATION INFLUENCES
- Family Characteristics/Dynamics
  - Family structure and roles
- Racial Socialization
  - Family, community, institutional

III. SOURCES OF STRESS
- Racism-Related Stress
  - Racism-related life events, daily racism microstressors, chronic conditions of living, collective/group perceptions, transgenerational transmission of trauma
- Other Status-Related Stress
  - Sexism, heterosexism. religious discrimination, disability discrimination, ageism, classism
- Generic Stressors
  - Episodic life events, daily hassles, role strain, multiple roles, role conflict

(*figure 3 continues)*

IV. INTERNAL AND EXTERNAL MEDIATORS

- Internal Characteristics
  - Self-esteem, self-efficacy, cognitive appraisal and attributions
- Sociocultural Variables
  - Worldview, cultural values, spirituality, racial/ethnic identity, racism-related coping styles, psychological acculturation, racial attitudes
- Affective and Behavioral Responses to Stress
  - Affective reactions (sadness, anger, humiliation, etc), specific coping behavior (problem-focused/emotion-focused, active/passive, inner-directed/outer-directed, individual/collective)
- External Resources
  - Social support (intragroup, community, intergroup, societal)

V. OUTCOMES

- Physical
  - Hypertension, cardiovascular reactivity, risk behavior (e.g., cigarette smoking)
- Psychological
  - Depression, anxiety, trauma-related symptoms, hostility
- Social
  - Social connectedness; intragroup, intergroup relations
- Functional
  - Job performance, academic achievement, parental functioning
- Spiritual
  - Loss of faith, meaninglessness, existential angst

Figure 3. Model of Racism-Related Stress and Well-Being: Domains and Selected Variables (Harrell, 2000).

Unlike general models of stress, these conceptualizations identify racism-related stress as a central source of stress. Racism-related stress refers to "transactions between individuals or groups and their environment that emerge from the dynamics of racism, and that are perceived to tax or exceed existing individual and collective resources or threaten well-being" (Harrell, 2000, p. 44). Harrell (2000) identified six types of racism-related stress: (a) racism-related life events (i.e., time limited life experiences that typically occur across various domains such as work, neighborhood, education, which can lead to other events or have lasting effects); (b) vicarious racism experiences (i.e., experiences through observation or report by individuals such as family,

close friends, or strangers that teach valuable lessons about where racism hides and resides); (c) daily racism microstressors (i.e., racial microaggressions that serve as daily reminders of one's status as a Black person such as being ignored, followed); (d) chronic-contextual stress (i.e., experiences related to "the impact of the social structure, political dynamics, and institutional racism on social-role demands and the larger environment within which one must adapt and cope" (Harrell, p. 46), as evidenced by the unequal distribution of resources and limited resources such as liquor stores on every corner, out of date textbooks in urban public schools); (e) collective experiences (i.e., experiences of racism at group level that take into account the impact of racism on members of one's same racial/ethnic group, regardless of personal or vicarious experience), and (f) transgenerational transmission (i.e., experiences grounded in past experiences/historical context that is transmitted across generations via discussions, storytelling, observations) (Harrell, pp. 45-46).

Overtime, racism-related stress can in turn be related to health outcomes. More specifically, the link between environmental stimuli perceived as racist and health outcomes can be moderated by a number of factors including: (a) internal characteristics (e.g., self-esteem, self-efficacy), (b) cultural and race variables (e.g., racial attitudes, psychological acculturation, racism-related coping styles), (c) affective and behavioral responses to stress (e.g., specific coping behavior, affective reactions), and (d) external resources (e.g., social support). For example, how people cope with racism-related stress as well as their racial attitudes might influence their overall health. More specifically, the relation between racism-related stress and health outcomes may be better accounted for when these factors are taken into consideration. This could in turn provide evidence for how racism-related stress could influence physical (e.g., hypertension, cardiovascular reactivity), psychological (e.g., depression, anxiety), social (e.g.,

social connectedness, intra and intergroup relations), functional (e.g., job performance, academic achievement), and spiritual (e.g., loss of faith, meaninglessness) outcomes.

Similarities and differences between BMPR and MRSW. The BMPR and MRSW are similar in terms of their conceptual framework and structure. The models have a common conceptual framework because both models are grounded in the interactional model of stress developed by Lazarus and Folkman (1984). According to this model, stress is "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, p. 19). In other words, the process of understanding stress consists of three parts: (a) a precipitating stressful event, (b) an appraisal process, followed by (c) coping strategies.

Similar to Lazarus and Folkman's (1984) conceptualization of the stress and coping process, both models include an appraisal of the event which ultimately shapes the physiological, psychological, and behavioral responses. Quite simply, appraisal is "the process of categorizing an encounter, and its various facets, with respect to its significance for well-being…it is largely evaluative, focused on meaning or significance, and takes place continuously during waking life" (Lazarus & Folkman, p. 31). Lazarus and Folkman discussed two types of appraisal: primary (i.e., the significance of the event in terms of its impact on individual's mental health) and secondary appraisal. Of particular interest in this study is secondary appraisal, which examines available coping options and the likelihood that a particular coping strategy can be applied to the stressful event.

According to the interactional model of stress, coping refers to the "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p.

141). In other words, coping refers to what individuals do in specific situations over time. Although both models are interaction models of stress (Lazarus & Folkman, 1984), there are key differences particularly in terms of antecedent variables (i.e., factors that influence an individual's perceptions). Specifically, the BMPR considers psychological and behavioral factors as being important in terms of understanding if an individual perceives an event as racist, which is not mentioned in the same way in the MRSW. Instead, the MRSW discusses familial and socialization experiences as being important to understanding why individuals perceive events as stressful. The difference in the models' conceptual frameworks may be related to theory. The BMPR is grounded in a medical model; whereas, the MRSW is grounded in an environmental or ecological model that incorporates factors related to the settings.

Integrated Model of Racism-related Stress

I propose an integrated model of racism-related stress in this study as a way to synthesize tenets of both the BMPR and MRSW. The integrated model draws on the conceptual strengths of both models to account for factors that may not have been fully explored in the other. In this study, I empirically test the proposed integrated model outlined in Figure 1 (see Chapter 1). Specifically, I test whether (a) antecedent variables (e.g., gender, age, SES, racial composition of neighborhood) and racial socialization influence racism-related stress, (b) whether racism-related stress in turn leads to negative health outcomes, and (c) whether the nature of these relations are moderated by cultural and race variables. The literature on core aspects of the integrated model is reviewed below.

Contextual Variables and Racism-related Stress

The potential influence of four antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization are examined on the basis of theory and some initial empirical data.

Gender. Research on the association between gender and racism-related stress are equivocal. Some studies suggest that Black men perceive more racism than Black women (Broman et al., 2000; Clark, 2004; Fischer & Shaw, 1999; McCord & Ensminger, 1997; Sellers & Shelton, 2003; Utsey et al., 2002). For example, in a longitudinal study among Black college students, Sellers and Shelton (2003) found significant gender differences on racism-related stress at the end of students' second semester, with men reporting greater levels of racism. On the hand, other studies have found that Black women perceive more racism (Gibbons et al., 2004) or that there is not an association (Branscombe et al., 1999; Swim et al., 2003). For example, Gibbons and colleagues (2004) examined the relation between racism-related stress and substance use among Black American families, and found that Black girls perceived more racism than Black boys.

More studies support the finding that Black men perceive more racism than Black women. It appears this finding is related to context. Black men perceive more racism in the context of employment, police, the legal system, money and finances, medical care, and being threatened and harassed (Broman et al., 2000; Clark, 2003; Clark, 2004). Few studies have examined the contexts that are relevant for Black women due to the complex nature of the intersection of race and gender (Woods-Giscombe´ & Lobel, 2008). In one of the few empirical examinations in this area, Jackson and colleagues (2001) found that Black women experienced "gendered racism" and experienced racism-related stress in the workplace as well as in

interpersonal relationships by feeling obligated to protect their children from racism. Additional research is needed to understand the racism-related stress among Black men and women.

Age. A number of studies found that age is related to racism-related stress, such that older Black Americans perceive more racism than younger individuals (Peters, 2004; Steffen et al., 2003). For example, Steffen and colleagues (2003) examined the effects of racism-related stress on ambulatory blood pressure in a community sample of Black American adults. They found that age was the only sociodemographic variable that was significantly correlated with racism-related stress. Other studies have found relations in the opposite direction or have not found significant differences (Clark, 2004; Kwate et al., 2003). For example, some studies found younger Black Americans perceived more racism than older Black Americans (Broman et al., 2000; Gary, 1995; Kennedy et al., 1997; Stancil et al., 2000). Broman and colleagues (2000) examined the experience and consequences of perceived racial discrimination among Black Americans. They found that younger Black Americans were more likely to perceive discrimination and that their experiences of racism were related to greater perceived stress.

One explanation for the differences in findings is there may not have been enough variability in the sample to accurately assess for age differences. Most of the studies used college students, thus there was a restricted age range. Other than this, there is not a clear pattern in the findings in terms of sample, measures, direction of the results, etc., thus it is difficult to make additional observations. A strength of the current this study is that it uses a community sample with a broader age range.

Socioeconomic status. Similar to age, the research findings on the association between socioeconomic status (SES) and racism-related stress is equivocal. It is important to note that SES has been measured in several ways including income, education, and class background. For

example in terms of income, studies have found that Black Americans with higher incomes, as indicated by annual income in dollar amounts, perceive more racism than Black Americans with lower incomes (Clark et al., 1999; Kennedy et al., 1997). In terms of education, studies have found that Black Americans who have more formal education perceive more racism than Black Americans with less formal education (Broman et al., 2000; Gary, 1995; Sigelman & Welch, 1991). In terms of class, some studies have found that individuals with a working class background were more likely to experience greater levels of racism-related stress compared to individuals with middle or upper class backgrounds (Forman et al., 1997; Sigelman & Welch, 1991). However, at least one study found that middle class or professional Black Americans reported greater levels of racism-related stress compared to working class Black Americans and that this relation had an impact on internalizing anger (i.e., keeping their anger to themselves) (Krieger et al., 1998). There are also studies that suggest there is not a relation between racism-related stress and SES (Broman et al., 2000; Fisher et al., 2000; Kwate et al., 2003).

It is unclear why there are differences in the results, as it does not seem to be linked to sample characteristics or the measures that were used because the different findings have been among college and community samples as well as with the measures used to assess racism-related stress. Similar to age, it is difficult to make additional observations. More research is needed to understand this relation or lack thereof.

Racial composition of contexts. Although both the BMPR and MRSW models consider the potential influence of socioenvironmental factors, few empirical studies have examined this association. Specifically, few empirical studies have examined the association between racism-related stress and the racial composition of the contexts in which a person lives and functions. Given the scarce research on racial composition, more studies are needed to understand the link

between racial composition and racism-related stress because the aforementioned study suggests that having the presence (i.e., support) of other Black Americans can mitigate negative consequences and increase positive attributes.

Socialization Influences and Racism-related Stress

Similar to the antecedent variables mentioned above, racial socialization is an important contextual factor to consider when examining racism-related stress (Hughes et al., 2006). In their review of the racial socialization literature, Hughes and colleagues (2006) found that racial socialization is associated with several outcomes including racial identity among Black adults as well as self-esteem, coping with racism-related stress, academic grades, and psychosocial outcomes (e.g., anger, depression) among Black adolescents. Additionally, they found the racial composition of individuals' neighborhoods predicted racial socialization, such that preparation for bias racial socialization messages were greater in integrated neighborhoods than in mostly Black or White neighborhoods (Hughes et al.).

Most of the research on racial socialization has focused on youth. Studies with Black adults have found that racial socialization aids Black college students adjusting academically (Anglin & Wade, 2007) and buffers against the negative impact of racism-related stress (Fischer & Shaw, 1999). For example, Fischer and Shaw (1999) found Black adults had lower overall mental health when they received fewer messages about how to cope with racism, regardless of having higher levels of self-esteem. However, greater racial socialization has also been found to be related to increased racism-related stress (Bynum et al., 2007). Bynum and colleagues (2007) found psychological stress was reduced when Black adults received messages about cultural resources they could use to cope with racism (e.g., Black history, collectivism, kinship);

however, receiving more messages about race and racism was also related to increased levels of racism-related stress. Bynum et al. suggested that receiving messages about race increased the participants' knowledge about the harsh reality of racism, which increased their burden psychologically. They also suggested the findings could be related to how they assessed racial socialization messages about cultural coping, which may not have sufficiently highlighted the nuances of the various ways to cope. Given these disparate findings it is important to continue to examine racial socialization and how it influences racism-related stress because it has been linked to negative health outcomes and higher levels of racism-related stress.

Racism-related Stress and Psychological Distress

Another component of the proposed integrated model of racism-related stress is health outcomes. Of particular interest in this study are psychological outcomes (i.e., psychological distress and anger). Psychological distress as a correlate of racism-related stress has been examined in several studies. In their meta-analysis, Pascoe and Richman (2009) found that discrimination in general has a negative effect on individuals' health, including their psychological well-being. The range of this effect was (r = -.15 to r = -.25). Furthermore, a narrative review of literature on racism-related stress and outcomes, found a positive relation between psychological distress and racism-related stress in 40 of the studies, although 21 studies found no association and one study found a negative association (Paradies, 2006). Paradies (2006) indicated that the differences in findings may be related to poor conceptualizations of racism-related stress. Among Black Americans specifically, studies have found that racism-related stress is significantly positively related to psychological distress (Brown et al., 2000; Bynum et al. , 2007; Carter et al., 2005; Hendryx & Ahern, 1997; Hope & Klonoff, 1996;

Jackson et al., 1996; Pieterse & Carter, 2007; Ren et al., 1999; Taylor & Turner, 2002; Williams et al., 1997) and race-related stress (Franklin-Jackson & Carter, 2007; Utsey et al., 2007; Utsey & Hook, 2007). Furthermore, some studies have found that racism-related stress was a stronger predictor of psychological distress (Brown et al., 2003; Franklin-Jackson & Carter, 2007; Utsey & Payne, 2000) more so than general stressful life events (Utsey et al., 2007). In sum, these studies suggest that psychological distress globally is an important mental health outcome to consider because it is a consequence of racism-related stress (Paradies, 2006; Pascoe & Richman, 2009).

Racism-related Stress and Anger

Another psychological outcome that is important to consider in understanding the impact of racism-related stress for Black Americans is anger. Anger is a common psychosocial response that individuals report feeling after they experience racism (Bullock & Houston, 1987). Moreover, there is evidence that anger can negatively affect an individual's physical health, as it has been significantly related to high blood pressure (Clark, 2006; Ewart & Kolodner, 1994) and cardiac and vascular functioning (Ewart & Kolodner, 1994; Hogan & Linden, 2004; Schum et al., 2003). Empirical studies consistently have found direct relations between racism-related stress and anger. For example, Wong and colleagues (2003) found that racism-related stress by peers and teachers was significantly related to increased levels of anger among Black American adolescents. Additionally, studies have found that among Black American adults racism-related stress was significantly related to anger (Combs et al., 2006), anger inhibition (i.e., anger remains contained due to a fear of expressing it) (Steffen et al., 2003), but not outwardly expressed anger (i.e., anger is directly expressed toward others) (Steffen et al., 2003). Taken together these

studies suggest that anger is an important mental health outcome to examine not only because it can lead to physical health problems, but because Black Americans can feel angry after experiences of racism, which could also take a toll on other dimensions of their psychological well-being.

Cultural and Race Processes as Moderators of the Racism-related Stress Health Link

Clark and colleagues (1999) and Harrell (2000) included cultural coping styles and racial attitudes in their models of racism-related stress. Consistent with their conceptualizations, the integrated model of racism-related stress incorporates these constructs as another component of the model. Specially, cultural coping and racial attitudes were tested as moderators of the relation between racism-related stress and health outcomes.

Cultural coping. One of the cultural and race processes examined in this study is coping. Studies have begun to focus on the cultural aspects of coping for Black Americans (Constantine et al., 2002; Utsey, Brown, & Bolden, 2004). These studies suggest that Black Americans are flexible and use a variety of strategies to cope with racism (Feagin, 1991; Harrell, 2000; Plummer & Slane, 1996). For example, some studies have found that Black Americans cope with racism-related stress by using cultural strategies such as disidentification, devaluing, and discounting when they feel they are being judged (e.g., underachievement in education) (Crocker & Major, 1989).

These various coping strategies may be related to the context in which the racism occurred, as evidenced by the different coping strategies Black Americans use when they experience racism (Feagin, 1991; Plummer & Slane, 1996). For example, Feagin (1991) conducted in-depth interviews with Black middle-class adults in several cities and found that

when Black Americans reported experiencing racism on the street they reported coping through withdrawal, resigned acceptance, or verbal retort; however, when they were in public accommodations they reported coping only through resigned acceptance or verbal retort.

Studies have also found that Black Americans' coping responses moderate the relation between racism and several mental health outcomes such as disgust and fear (Jones, Harrell, Morris-Prather, Thomas, & Omowale, 1996), and posttraumatic stress disorder with symptoms such as intrusion (e.g., nightmares, disturbing thoughts and images) and avoidance (e.g., denial, behavioral inhibition) (Thompson, 1996). Specifically, Armstead and colleagues (1989) found that racist stimuli were significantly associated with higher blood pressure increases more so than anger-provoking stimuli and that suppressing one's anger can lead to an increase in blood pressure. In other words, researchers have found that Black Americans who cope with racism with coping methods such as avoidance, acceptance, using denial, or suppressing emotional reactions about their experience, such as feeling angry, had higher blood pressure (Armstead, Lawler, Gorden, Cross, & Gibbons, 1989) compared to those who reported coping methods such as challenging racial discrimination (Krieger & Sidney, 1996). Moreover, Utsey, Ponterotto and colleagues (2000) found Black Americans who cope with racism via avoidance coping methods had lower levels of life satisfaction and self-esteem. Furthermore, Black women used avoidance coping more than seeking social support and problem-solving when they experienced individual racism as opposed to other forms of racism (i.e., institutional and cultural racism) (Utsey, Ponterotto et al., 2000).

About a decade ago, Utsey, Adams and colleagues (2000) developed one of the few culturally relevant coping measures for Black Americans, the Africultural Coping Systems Inventory (ACSI). The scale measures four distinct culture-specific coping styles:

Cognitive/Emotional Debriefing (i.e., basic survival and adaptive reactions to manage environmental stressors, that may have developed because of slavery and racial oppression) Spiritual-Centered (i.e., core component of the African personality, which values a connection to spirits and a higher power), Collective (i.e., African-based cultural system which values group over self), and Ritual (i.e., African-based cultural practice that relies on practices aimed at providing guidance and strength). Findings with the ACSI in this area suggest spiritual and collective coping strategies significantly predict a higher quality of life among Black American adults more so than traditional predictors of quality of life (e.g., family cohesiveness and adaptability) (Utsey et al., 2007). Furthermore, Constantine and colleagues (2002) found collective self-esteem was related to the use of more collective coping strategies among Black adolescents.

These studies suggest that there is a direct link between the way Black Americans cope with stress and negative outcomes. They also suggest that coping can moderate the relation between racism-related stress and negative outcomes. Specifically, the research findings suggest that cultural forms of coping may be more effective in mitigating the harmful effects of racism-related stress; therefore it important to continue to understand how coping is related to racism-related stress. It is also important to examine how racial attitudes might moderate the relation between racism-related stress and health outcomes as well.

Color-blind racial ideology (CBRI). Similar to coping, racial attitudes are important constructs in understanding the impact of racism on individuals. In the integrated model of racism-related stress, I propose that racial attitudes moderate the relation between racism-related stress and health outcomes and this study assessed an emerging construct – racial color-blindness. Color-blind racial ideology (CBRI) "is to deny the existence of ideological and

structural racism and to believe that race does not play a meaningful role in people's lived experiences" (Neville, Worthington, & Spanierman, 2001, p. 270). In the past few years, research has emerged on CBRI because it provides insight into modern racial attitudes and beliefs, such as an individual's perceptions of structural racism.

Research, both qualitative and quantitative, on racial color-blindness among racially diverse adults provides empirical support for the importance of examining individuals' attitudes about race and racism. For example, Bonilla-Silva (2003) examined CBRI among Black adults. Using interview data he found that social actors' lives are structured around racial ideology because it is systemic and global. Specifically, society is structured around the dominant culture's ideals and views, which affects how individuals that are not a part of the dominant culture feel about themselves (Bonilla-Silva, 2003). Bonilla-Silva found that due to the pervasive nature of racial ideology, Black people internalized negative stereotypes from the dominant culture about themselves (Bonilla-Silva, 2003). Moreover, some Black interviewees assimilated to the norms of the dominant culture, including valuing individuality over collectivism (Bonilla-Silva, 2003).

In addition to the qualitative research on color-blind racial ideology, there have also been quantitative studies. The Color-blind Racial Attitudes Scale (CoBRAS) was developed to assess racial color-blindness. The CoBRAS has three components including: racial privilege, "blindness of the existence of White privilege" (Neville, Lilly, Duran, Lee, & Browne, 2000, p. 63); institutional discrimination, "a limited awareness of the implications of institutional forms of racial discrimination and exclusion" (Neville, Low, Walters, Liao, & Landrum-Brown, 2003, p. 63); and blatant racial issues, "unawareness to general, pervasive racial discrimination" (Neville et al., 2003, p. 63). Studies have found that the CoBRAS is a reliable measure among adults and

college students (Neville et al., 2000). The CoBRAS was found to be related to internalized oppression and anti-egalitarian beliefs among Black Americans (Neville et al., 2005). Furthermore, individuals with higher levels of CBRI were more likely to be against racism-related programs such as affirmative action and were less likely to be involved in an anti-racist campus activity (Neville et al., 2003).

Although the aforementioned studies are important to understanding modern racial attitudes and beliefs, the studies do not examine how these attitudes may influence racism-related stress and in turn outcomes related to health. As such, CBRI was included as a variable in the integrated model of racism-related stress. Specifically, CBRI may moderate the relation between racism-related stress and health outcomes. For example, based on CBRI's conceptual framework, individuals who report lower levels of racial color-blindness (i.e., less likely to deny the existence of racism) may be able to buffer the negative impact of racism because they are more aware of systematic discrimination; therefore they can externalize discrimination and try to cope with it. On the other hand, individuals who report higher levels of racial color-blindness (i.e., more likely to deny the existence of racism) may be at risk of internalizing discrimination because they minimize systemic problems, which in turn could lead to negative health outcomes. For instance, research on CBRI among Black Americans suggests that limited awareness of institutional racism is related to reports of receiving fewer messages to protect individuals against racism and racial barriers (Barr & Neville, 2008), which may lead to negative consequences such as assimilation (i.e., valuing individuality instead of collectivism) (Bonilla-Silva, 2003) and internalized oppression (Bonilla-Silva, 2003; Neville et al., 2005). Similarly, CBRI may moderate the relation between racism-related stress and health, such that an individual views an event as racist, but can minimize the racist event, (similar to avoidance

coping), which could make them more at risk for negative mental health outcomes. This in turn could affect an individual's health (e.g., internalizing oppression).

Rationale and Purpose

There are several gaps in the racism-related stress literature. First and foremost, most studies on racism-related stress have been atheoretical. An integrated model of racism-related stress is used in the current study to incorporate aspects of both the BMPR and MRSW, which could be helpful in understanding the impact racism-related stress has on health in a more comprehensive way. The proposed model draws on the conceptual strengths of both models to account for factors that may not have been fully explored in the other.

Second, it is unclear whether antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization influences racism-related stress due to mixed findings and links with negative health outcomes. For that reason, it is important to continue to explore this potential association. Third, a meta-analysis found discrimination in general has a negative effect on individuals' health, including their psychological well-being (Pascoe & Richman, 2009). As such, it is important to examine racism-related stress because it can lead to serious health risks. In this study, I explore mental health by examining psychological distress and anger. Among Black Americans, studies have found that racism-related stress is significantly positively related to psychological distress (Brown et al., 2000; Bynum et al., 2007; Carter et al., 2005; Hendryx & Ahern, 1997; Hope & Klonoff, 1996; Jackson et al., 1996; Pieterse & Carter, 2007; Ren et al., 1999; Taylor & Turner, 2002; Williams et al., 1997). Additionally, anger is a common psychosocial response that individuals report feeling after they experience racism (Bullock &

Houston, 1987) and it can have a negative impact on individual's physical health (Clark, 2006; Ewart & Kolodner, 1994; Hogan & Linden, 2004; Schum et al., 2003).

Fourth, it is important to explore how cultural coping styles influence racism-related stress and health outcomes, because it has been consistently related to negative health outcomes. Additionally, coping may moderate the link between racism-related stress and psychological health such that certain coping styles might mitigate the impact of racism-related stress better than others. Finally, the integrated model of racism-related stress suggests that racial attitudes, particularly CBRI, may moderate the relation between racism-related stress and health particularly when individuals deny the existence of racism, which could in turn affect an individual's health.

On the basis of these limitations, the purpose of this study is to empirically test an integrated model of racism-related stress. Specifically, I test the integrated model by: (a) examining whether person (e.g., gender, and age), socioenvironmental (e.g., SES, racial composition), and racial socialization influence racism-related stress; (b) examining the relation between racism-related stress and health outcomes (i.e., psychological distress and anger); and (c) examining whether cultural and race variables such as cultural coping and racial color-blindness (i.e., racial attitudes) moderate the relation between racism-related stress and health outcomes among Black Americans.

Chapter Three

Methodology

Participants

One hundred and eighty-five self-identified Black men (*n* = 49; 27.4%) and women (*n* = 130; 72.6%) from either a large Midwestern (*n* = 60; 32.4%) or Southern (*n* = 125; 67.6%) city participated in the study. The sample ranged in age from 18 to 81 (*M* = 52.82; *SD* = 13.48). The majority of the sample reported their ethnicity as African American (*n* = 164, 72.9%), while 19 other participants indicated other categories such as African, Afro-Caribbean American, Black. In terms of participants' highest educational background: six (3.4%) participants completed some high school, 19 (10.7%) had a high school diploma or equivalent, 55 (30.9%) completed some college, 53 (29.8%) completed at least a college degree, and 45 (25.3%) completed graduate or professional school. Nearly two-thirds of the sample was employed full-time (*n* = 94, 62.7%); 19 (12.7%) was employed part-time and the rest was unemployed (*n* = 37, 24.7%). Based on the 2000 census job categories, participants reported employment across several broad categories. The categories with the highest numbers of participants included: Officials and Mangers (*n* = 23, 16.3%), Professionals (*n* = 23, 16.3%), Administrative Support Workers (*n* = 15, 10.6%), Service Workers (*n* = 9, 6.4%), Operatives (*n* = 6, 4.3%); a significant percentage of the sample did not provide include this information (*n* = 44, 23.8%). Participants on average reported that their class status was close to middle class (*M* = 4.64; *SD* = 1.72). The overwhelming majority of the sample reported they voted Democrat during the last election (*n* = 159, 92.4%). The majority of participants indicated they were Christian (*n* = 117; 67.7%).When asked about their level of

religiosity/spirituality, almost all of the participants indicated they were either somewhat religious/spiritual (n = 50, 31.1%) or very religious/spiritual (n = 104, 64.6%).

Measures

Demographics sheet. A thirteen question demographic sheet was created for this study and included questions about participants' age, sex, educational background, racial and ethnic background, religious background, level of religiosity/spirituality, political affiliation, employment status, occupation, physical and mental health status, and socioeconomic status.

Sociodemographic variables. Four sociodemographic variables were assessed in the study. Age and sex were self-reported on the demographic sheet.

Socioeconomic status (SES) was assessed using self-report and census items. Four self-report questions were included to examine SES: two questions on occupation, another on education level, and the last on class background. Specifically, participants were asked the following questions: Occupation – "Are you employed" and "What is your current occupation?;" Education – "What's the highest level of education you have completed?," with responses ranging from Elementary school (8th grade) to advanced degrees; Class Background – "Think of this ladder as representing where people stand in our society. At the top of the ladder are the people who are the best off – those who have the most money, most education and best jobs. At the bottom are the people who are the worst off – who have the least money, least education, and the worst jobs or no jobs. The higher up you are on this ladder, the closer you are to the people at the very top and the lower you are, the closer you are to the people at the very bottom. Please mark an 'X' on the rung on the ladder where you would place yourself; you can mark the 'X'

anywhere on the line below that best describes your current social position." Responses range from people who are the best off (1) to people who are the worst off (10).

Two census related questions were also included to examine SES: one question asked participants to include their current address and the other question asked how long the participant lived at that address. I used the 2000 census database to obtain the following information about participant's neighborhoods: size, racial composition, income levels for both the household and family (i.e., above or below poverty), and number of renter versus owners. The data were obtained using the following URL: http://factfinder.census.gov/servlet/AGSGeoAddressServlet?_lang=en&_programYear=50&_treeId=420. The address was entered and the county, census track number, and block group number was obtained. Then housing (i.e., census tract, block group, occupied units – rented and owned), income (i.e., household and family) and poverty level was obtained using "Census 2000 Summary File 3 (SF 3) - Sample Data" data file.

Racial composition was assessed via a self-report scale and U.S. census data. The Racial Composition subscale which is part of the Racism and Life Experiences Scales (RaLES; Harrell, 1997) was used to capture self-reported racial composition. The 10-item Racial Composition subscale assesses the influence of current and past environmental and personal contexts by asking participants about the racial composition of various contexts. Responses were rated on a 6-point scale ranging from 0 (*does not apply to me*) to 5 (*mostly or entirely White*). Example items include: "Your current job" and "Your close friends now." Scores were attained from the sum and average of scores, thus scores range from 0 to 100. Higher scores indicate more exposure to racial/ethnic groups other than one's own. The subscale has also been found to have adequate construct validity, such that it has been significantly negatively related to social

desirability, private collective self esteem (i.e., one's personal feelings about being a member of their racial/ethnic group), and cultural mistrust (Harrell, Merchant, & Young, 1997). The Racial Composition subscale has also been found to be positively related to positive well-being, perceived stress, and psychological symptoms (Harrell et al., 1997). Cronbach's alpha for this scale among racially diverse samples has ranged from .73 to .77 (Harrell et al., 1997). In this study, the alpha was .82.

Racial composition was also assessed using U. S. census data. This information was obtained using the same method described in the sociodemographic section in regards to SES. The racial composition of participants' neighborhood was coded as either Black or non-Black (i.e., White, Native American, Asian, Pacific Islander, Multiracial, and Hispanic). In this study, on average, participants lived in neighborhoods that were 70% Black (M = 70.15; SD = 35.42).

Racial socialization. Racial socialization was measured using the 5-item Social Influences subscale of the Racism and Life Experiences Scales (RaLES; Harrell, 1997). The Social Influences subscale assesses the frequency and content of racism-related messages from five sources (i.e., parents, other family, friends, teachers, and place of worship) in participants' lives while they were growing up. Responses were rated on a 5-point Likert-type scale ranging from 0 (*not at all*) to 4 (*extremely so*). Scores are attained from the sum and average of scores. Total scores can range from 0 to 20, with higher scores indicating more discussion of race and racism while one was growing up from the people listed in the scale. There is support for the validity of the subscale, such that it has been significantly negatively related to public collective self-esteem (i.e., one's perceptions of how others view their racial/ethnic group) as well as significantly positively related to identity collective self-esteem (i.e., how meaningful one's racial/ethnic group is for their self-image), racial identification salience (i.e., how important race

is to self-concept and identity), and cultural mistrust (Harrell et al., 1997). Furthermore, significant positive criterion validity has been found with urban stress (i.e., exposure to stressors frequently identified by urban, low-income, and minority populations such as money, relationship with the police) (Harrell et al., 1997). Cronbach's alphas for this scale among racially diverse samples have ranged from .70 to .77 (Harrell et al., 1997) and .84 among Black adolescents (Scott, 2003; Scott, 2004). In this study, the alpha was .87.

Racism-related stress. The 20-item Daily Life Experiences Scale (DLE; Harrell, 1997) of the Racism and Life Experiences Scale (RaLES; Harrell, 1997) was used to assess racism-related stress. The DLE assesses the frequency in which participants perceive racism-related microaggressions in their routine, day-to-day experiences. Responses were rated on a 6-point scale ranging from 0 (*never*) to 5 (*once a week or more*). Example items for the DLE include: "Being ignored, overlooked, or not given service (in a restaurant, store, etc.)" and "Being stared at by strangers." Scores are attained from the sum and average of scores, thus total scores range from 0 to 100. Higher scores indicate higher levels of racism-related stress. The scale has been found to have adequate construct validity, such that it has been significantly related to racial identity salience and collective self-esteem (i.e., how important one's race is to his/her self-image) (Harrell et al., 1997). The DLE has also been significantly positively related to race-related stress (Liang, Alvarez, & Liang, 2007) and active, avoidance, and support seeking coping styles among racially diverse populations (Liang et al., 2007) and externalized coping among young Black adults (Scott & House, 2005). Furthermore, the reported coefficient alphas have ranged from .84 (Harrell, 1997) to .94 (Harrell et al., 1997), with a split half reliability coefficient of .79 (Harrell, 1997). Coefficient alpha for this scale among racially diverse college students has ranged from .89 (Harrell et al., 1997) to .94 among Asian American college students

(Liang et al., 2007) and young Black adults (Caldwell, Kohn-Wood, Schmeelk-Cone, Chavous, & Zimmerman, 2004). In this study, the alpha was .94.

Cultural and race processes. Two cultural and race processes were assessed in this study: cultural coping and racial attitudes (i.e., racial color-blindness).

Cultural coping. The 30-item Africultural Coping Systems Inventory (ACSI; Utsey et al., 2000) was used to assess culture-specific coping. The original directions for the ACSI state: "The statements below are intended to represent some of the ways people cope with stressful situations in their daily lives. In order to respond to the statements below you will need to think of a specific stressful situation that you may have encountered within the past week or so. A "stressful situation" is any situation that you found troubling or otherwise caused you to worry. Such situations might have been related to your family, friends, school, job, romantic relationship, or other things you consider important in your life. To help us better understand the exact nature of the stressful situation you are thinking of when responding to the statements in this questionnaire, please take a moment to write a brief description of the situation in the space provided below. Use this space to describe your stressful situation:…DID YOU REMEMBER TO DESCRIBE YOUR STRESSFUL SITUATION? Now, keeping this situation in mind, please indicate the extent to which you used each of the strategies described on the following pages to help you cope with the stress you experienced." Given this study was interested in racism-related stress and the ways people cope with that stress, the ACSI was modified and participants were asked to think of a racially stressful situation or event that occurred within the past year or so and to write a brief description of the stressful situation.

Then they were asked to rate the extent to which they used certain Africultural coping strategies to deal with the stressful situation they described. Responses were rated on a 4-point

scale ranging from 0 (*does not apply/did not use*) to 3 (*used a great deal*). Scale scores were obtained by summing the items across four distinct culture-specific coping styles: Cognitive/Emotional Debriefing (i.e., adaptive reaction to survive and manage environmental stressors), Spiritual-Centered (i.e., connection with spiritual elements and the Creator), Collective (i.e., relying on group-centered activities), and Ritual (i.e., acknowledging the role of ancestors, celebrating events, and paying homage to various religious deities). Higher scale scores indicated greater use of the specific coping style in response to stressful events. Sample items include: Cognitive/Emotional Debriefing (e.g., "Tried to forget about the situation" and "Got dressed up in my best clothing"); Spiritual-Centered (e.g., "Asked someone to pray for me" and "Left matters in God's hands"); Collective (e.g., "Helped others with their problems" and "Sought emotional support from family and friends"); and Ritual (e.g., "Lit a candle for strength or guidance in dealing with the problems" and "Burned incense for strength or guidance in dealing with the problem").

Concurrent validity has been supported with the positive associations with most of the Ways of Coping Questionnaire subscale scores (Utsey, Adams, et al., 2000). Confirmatory factor analysis found the four subscales to have the best fit for the data. Among Black Americans, all four subscales have been significantly and positively related to daily stress, stressful life events (e.g., police brutality), race-related stress, quality of life (Utsey et al., 2007), and religious problem solving (Lewis-Coles & Constantine, 2006). Cronbach alphas for the subscales have ranged from: .80 - .84 Cognitive/Emotional Debriefing, .79 - .87 Spiritual-Centered, .71 - .82 Collective, and .74 - .75 Ritual (Lewis-Coles & Constantine, 2006; Utsey, Bolden, Lanier, & Williams III, 2007; Utsey, Adams, et al., 2000). In this study, the alpha for each subscale was:

.86 Cognitive/Emotional Debriefing, .88 Spiritual-Centered, .84 Collective, and .75 Ritual, but only the Collective and Ritual subscales were used in the analyses.

Racial attitudes. The 14-item CoBRAS-Short Form (CoBRAS-SF; Neville et al., 2003) was used to assess colorblind racial ideology (CBRI). The CoBRAS measures racial attitudes in which the existence of racism is denied, distorted, and/or minimized. Responses were reported on a 6-point Likert-type scale ranging from 1 (*strongly disagree)* to 6 (*strongly agree)*. The CoBRAS has three subscales: racial privilege, institutional discrimination, and blatant racial issues. Sample items include: Racial privilege subscale (e.g., "Race is very important in determining who is successful and who is not") (reverse scored); Institutional discrimination subscale (e.g., "White people in the U.S. are discriminated against because of the color of their skin"); and Blatant racial issues subscale ("Racism may have been a problem in the past, but it is not an important problem today"). Total scores can range from 14 to 84, with higher scores indicating greater levels of CBRI.

Convergent validity for the original CoBRAS has been found with other racism-related measures such as the Modern Racism Scale (McConahay, 1986) and the Quick Discrimination Index (Ponterotto et al., 1995) among primarily White individuals (Neville et al., 2000). The CoBRAS has also been related to internalized oppression, victim blame ideology, and anti-egalitarian beliefs among Black Americans (Neville et al., 2005); multicultural counseling processes among racially diverse samples (Burkard & Knox, 2004; Gushue, 2004; Neville, Spanierman, & Doan, 2006); as well as white racial identity attitudes (Gushue & Constantine, 2007). Additionally, CoBRAS has been related to sociodemographic factors such as gender, with women reporting a higher awareness of racial issues (Buttner, Lowe, Billings-Harris, 2007). Coefficient alphas for the CoBRAS subscales have ranged from .61 (Blatant Racial Issues) to .80

(Racial Privilege) (Gushue & Constantine, 2007). Coefficient alphas for the total scale have ranged from .81 (Awad, Cokley, & Ravitch, 2005) to .91 (Neville et al., 2000). Alpha for the total scale of the CoBRAS among a Black American sample has ranged from .64 to .74 (Barr & Neville, 2008). The total score among the samples has been consistent over time; the 2-week test-retest reliability estimate for the CoBRAS total score was .68 (Neville et al., 2000). The alpha for the total score in this study was .61.

Psychological outcomes. Two psychological outcomes were assessed in this study: psychological distress and anger.

Psychological distress. The 5-item *Mental Health Inventory 5 (MHI-5; Viet & Ware, 1983),* a shortened version of the 38-item MHI, was used to assess psychological distress. This index measures mental health based on well-being and psychological distress. Participants were asked to report the duration of a particular feeling over the past month. Responses were on a 6-point Likert-type scale ranging from 1 (*all of the time*) to 6 (*none of the time*). Example items include: "Been a very nervous person" and "Felt downhearted and blue." Scores can range from 5 to 30, with higher scores indicating greater levels of psychological well-being. A confirmatory factor analysis found the MHI to have a two-factor structure: psychological distress - which is characterized by anxiety, depression, and loss of behavioral/emotional control - and psychological well-being - which is characterized by general positive affect and emotional ties (Viet & Ware, 1983). The MHI has been significantly and positively related to social support and life satisfaction, and significantly and negatively related to stressful life events and a history of emotional problems (Ware et al., 1984). Furthermore, Manne and Schnoll (2001) found that the MHI was related to positive affect (enthusiastic and alert) and negative affect (hostile and nervous) and psychological adjustment in the expected direction among adult cancer patients.

Reliability estimates for the MHI-5 total score have ranged from .74 (Berwick et al., 1991) to .89 (McHorney & Ware, 1995). In this study, the alpha was .73.

Anger. Anger was assessed using the *Multidimensional Anger Inventory (MAI; Siegel, 1986)*. The MAI assesses the emotional, attitudinal, and behavioral components of anger and was developed to measure six components of anger: frequency (i.e., how often an individual gets angry); duration (i.e., how long the individual remains angry); magnitude (i.e., the intensity of the anger), hostile outlook, range of anger-eliciting situations (i.e., circumstances in which the individual might become angry), and mode of expression (i.e., how the individual expresses anger). This study used two of the 5 MAI subscales: the 12-item Hostile Outlook (i.e., the degree to which a person has an angry stance toward others and the environment) and Anger-in (i.e., mode of expression - suppressing anger). The 6-item Anger-in scale was modified to assess participant's anger as it relates to experiences of racism; therefore, the following phrase was added to the measure "Thinking about a time in which you experienced racism, please respond to the following items." Sample items include: Hostile outlook subscale (e.g., "People can bother me just by being around") and Anger-in subscale (e.g., "Even after I have expressed my anger, I have trouble forgetting about it"). Responses are rated on a 5-point Likert-type scale ranging from 1 (*completely undescriptive*) to 5 (*completely descriptive*). Scores on the Hostile Outlook subscale can range from 12 to 60. Scores on the Anger-in subscale can range from 6 to 30, with higher scores indicating greater levels of anger on both subscales.

The MAI has been significantly negatively related to depression and significantly positively related to high blood pressure (Siegel, 1992). Furthermore, it has been significantly positively related to racism-related stress among Black Americans (Steffen et al., 2003). Convergent validity for the MAI has been found with other anger measures such as the State-

Trait Anger Scale (Spielberger, Jacobs, Russell, & Crane, 1983), Buss-Durkee Hostility Scale (Buss & Durkee, 1957), Harburg Anger-Out Scale (Harburg, 1973), and Novaco Anger Inventory (Novaco, 1975) (Riley & Treiber, 1989; Siegel, 1986). The 3 to 4 week test-retest reliability estimate for the MAI is .75 (Siegel, 1986). Internal consistency for the MAI total score has ranged from .84 to .91 (Rogge & Bradbury, 1999; Siegel, 1986). For the subscales, alphas have ranged from .63 (Hostile Outlook and Anger-in subscales) to .83 (Anger Arousal subscale) (Siegel, 1986). The alpha for the Anger-out subscale is not reported because it was not used in this study and because it only has 2 items. In this study, the alpha for the Hostile Outlook subscale was .86 and for Anger-in subscale was .88.

Procedure

Participants in this study were recruited from a Baptist church in Chicago and a National Conference for the Masonic Lodge in Alabama. After receiving approval from the Institutional Review Board (IRB), the pastor from the church and the president of the Masonic Lodge were contacted. Permission was granted to collect data during church on a Sunday for the Baptist church setting and during one of the conference days for the Masonic Lodge setting. Three African American researchers aided in data collection. Upon arrival, one of the researchers explained the purpose of the study, the approximate length (i.e., 20 minutes), and the voluntary nature of the survey to the attendees. The research packets included an informed consent document for the participant to retain for their record, the survey, and community resources which included contact information for mental health organizations and books about racism. At the Baptist church, participants remained seating and completed the surveys after the church

service. At the conference, participants completed the survey at their leisure and returned the surveys by the end of the conference.

To test for ordering effects, there were two versions of the survey in which the CoBRAS and DLE were either at the beginning or end of the survey. The survey took approximately 20 minutes to complete. Participants were given options for a snack as a token of appreciation for participating. Twenty-eight participants did complete more than fifty percent of the survey; therefore they were deleted from the final data set. In sum, of the 213 surveys that were collected and 185 were used in the final data analyses.

Chapter Four

Results

Data Cleaning

Surveys were double entered and coding discrepancies were identified and corrected by comparing the data to the surveys themselves. The normal distribution of the variables was examined. All but one variable met the assumptions of normality (i.e., the skewness and kurtosis estimates were $\pm$ 2; Tabachnick & Fidell, 2006); the Africultural Coping Systems Inventory Ritual Coping Style subscale was positively skewed (skewness = 1.651; kurtosis = 2.025) and thus was transformed using the square root transformation. After transformation, the skewness and kurtosis was .818, -.772, respectively. Outliers were indentified for relevant scales, which were the Daily Life Experiences scale (6 outliers), the Mental Health Inventory – 5 (3 outliers), and Multidimensional Anger Inventory's Hostile Outlook subscale (1 outlier). The scales were graphed using a histogram, and the identified outliers were replaced with adjacent values from the specific scale (Barnett & Lewis, 1994).

Preliminary Data Analysis

Table 1 contains means, standard deviations, and alphas and Table 2 contains the zero order correlations among the study variables. The mean scores for participants' subjective evaluation of their current physical (M = 4.03; SD = .65) and mental health (M = 4.53; SD = .59) was "good." The mean scores on the Racial Composition subscale indicated participants' environmental and personal contexts mostly consisted of other Black people (M = 1.75; SD = 0.72). Mean scores on the Social Influences subscale indicated participants received some

Table 1

Means, Standard Deviations, and Alphas Among Relevant Variables

Measure	*n*	*α*	*M*	*SD*
1. Form	185	-	-	-
2. Gender	179	-	-	-
3. Class	146	-	-	-
4. % of house below poverty	107	-	17.22	12.25
5. Education	178	-	-	-
6. Age	170	-	52.82	12.48
7. Social Influences	179	.87	2.12	.98
8. Racial Composition	161	.82	1.75	.72
9. % of Black Ppl in Neighborhood	107	-	70.15	35.42
10. DLE	180	.94	1.46	.84
11. CoBRAS	175	.61	2.72	.66
12. Cog./Emo. Debriefing Coping	167	.86	14.30	.66
13. Spiritual-Centered Coping	169	.88	14.24	.78
14. Collective Coping	169	.84	12.64	.69
15. Ritual Coping	165	.75	1.26	.54
16. MHI-5	178	.73	2.33	.86
17. Anger-in	169	.88	2.41	1.03
18. Hostile Outlook	174	.86	2.65	.79

(continued)

Table 1 (continued)

Note. Form = two versions of the survey (i.e., 0 = form A; 1 = form B); Class = subjective SES status as measured by ladder; % of house below poverty = percent of household below poverty level as measured by the census data; Social Influences = racial socialization; Racial Composition = racial composition as measured by Harrell subscale (1997); % of Black Ppl in Neighborhood = percent of neighborhood composed of Black people as measured by census; DLE = Daily Life Experiences Scale; CoBRAS = Color-blind Racial Attitudes Scale – Short Form; Cog./Emo. Debriefing Coping = ACSI's cognitive/emotional debriefing coping subscale; Spiritual-Centered Coping = ACSI's spiritual-centered coping subscale; Collective Coping = ACSI's collective coping subscale; Ritual Coping – ACSI's ritual coping subscale; MHI-5 = psychological distress; Anger-in = MAI's Anger-in subscale; Hostile Outlook = MAI's hostile outlook subscale.

$^{*}p < .05$, $^{**}p < .01$.

Table 2

Intercorrelations Among Relevant Variables

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. Form	-	.08	.04	-.12	-.07	.00	.05	-.06	-.08	.07	-.01	.21**	.13	.16*	-.04	-.15	-.09	.16*	.11
2. Gender		-	-.04	-.16	.03	.11	-.07	-.18*	.17	-.13	-.06	.08	.05	.25**	.11	.03	.04	-.04	.03
3. Class			-	-.02	-.01	-.16	-.14	-.12	.08	-.08	.14	-.08	-.08	-.06	.12	.04	.22*	.11	.11
4. % of house below poverty				-	-.09	.06	.12	.01	.42**	.03	-.08	.02	-.15	-.26**	-.27**	-.02	.14	-.01	-.02
5. Education					-	-.07	.06	-.02	-.23*	.05	.07	-.19*	-.06	-.07	.06	-.06	-.22**	-.06	-.02
6. Age						-	-.01	-.20*	.32**	-.04	-.04	-.07	-.09	-.01	-.21**	-.25**	-.05	.04	-.04
7. Social Influences							-	.29**	-.08	-.00	.19*	.01	.16*	.09	.10	.12	.07	.19*	.25**
8. Racial Composition								-	-.35**	.14	.33**	.11	.13	.07	.03	.24**	.03	.12	.11
9. % of Black ppl in neighborhood									-	-.51**	-.25**	-.07	-.08	-.04	-.13	-.14	.07	.02	-.09
10. Location										-	.04	-.06	-.11	-.14	-.09	.09	-.10	-.03	-.04

(continued)

Table 2 (continued)

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
11. DLE											-	-.04	.31**	.23**	.26**	.35**	.27**	.42**	.32**
12. CoBRAS												-	.12	.17*	-.05	.25**	.03	.06	.00
13. Cog./Emo. Debriefing Coping													-	.69**	.63**	.51**	.38**	.35**	.20*
14. Spiritual-Centered Coping														-	.64**	.42**	.17*	.17*	.13
15. Collective Coping															-	.41**	.29**	.19*	.13
16. Ritual Coping																-	.39**	.28**	.21**
17. MHI-5																	-	.25**	.20*
18. Anger-In																		-	.66**
19. Hostile Outlook																			-

(continued)

Table 2 (continued)

Note. Form = two versions of the survey (i.e., 0 = form A; 1 = form B); Gender = gender of participant (i.e., 0 = male; 1 = female; Class = subjective SES status as measured by ladder; % of house below poverty = percent of household below poverty level as measured by census data; Location = location for data collection; Social Influences = racial socialization; Racial Composition = racial composition as measured by Harrell subscale (1997); % of Black ppl in neighbor. = percent of neighborhood composed of Black people as measured by census; DLE = Daily Life Experiences Scale; CoBRAS = Color-blind Racial Attitudes Scale – Short Form; Cog./Emo. Debriefing Coping = ACSI's cognitive/emotional debriefing coping subscale; Spiritual-Centered Coping = ACSI's spiritual-centered coping subscale; Collective Coping = ACSI's collective coping subscale; Ritual Coping – ACSI's ritual coping subscale; MHI-5 = psychological distress; Anger-in = MAI's Anger-in subscale; Hostile Outlook = MAI's hostile outlook subscale.

$*p < .05$, $**p < .01$.

racism-related messages from family members and other important adults in their life while they were growing up (*M* = 2.12; *SD* = 0.98). The mean scores on the Daily Life Experiences Scale (DLE) indicated participants on average experienced racism a couple times a year (*M* = 1.46; *SD* = 0.84), which is consistent with previous research among Black Americans (Williams et al., 1997). The mean scores on the Africultural Coping Systems Inventory (ACSI) subscales indicated that participants used various coping strategies. Specifically, participants used Cognitive/Emotional Debriefing (*M* = 14.30; *SD* = 0.66), Spiritual-Centered (*M* = 14.24; *SD* = 0.78), and Collective (*M* = 12.64; *SD* = 0.69) coping styles some, and used Ritual coping styles very little (*M* = 1.26; *SD* = 0.54). Mean scores on the CoBRAS indicated participants reported low to moderate levels of racial color-blind ideology (*M* = 2.72; *SD* = 0.66), which is also consistent with previous research among Black Americans (Neville et al., 2005). Mean scores on the Mental Health Inventory 5 (MHI-5) indicated participants reported moderately high levels of psychological distress (*M* = 2.33; *SD* = .86).The mean scores on the Multidimensional Anger Inventory's (MAI) Hostile Outlook subscale indicated participants on average had a somewhat angry stance toward others and the environment (*M* = 2.65; *SD* = 0.79). Additionally, the Anger-in subscale of the MAI indicated that participants on average suppressed their anger somewhat when thinking about racism (*M* = 2.41; *SD* = 1.03), which is consistent with previous research among Black Americans (Steffen et al., 2003).

Zero-order correlations were conducted to examine whether antecedent variables (i.e., gender, age, SES, and racial composition), racial socialization, cultural and racial attitude variables (i.e., cultural coping and CBRI), and psychological outcomes (i.e., psychological distress and anger) were related to racism-related stress. Findings suggested that racism-related stress as measured by the DLE was significantly related to: (a) racial composition as measured

by the census data for residents that resided in a predominately Black neighborhood (r = -.25**) and Harrell's Racial Composition subscale (1997) (r = .33**); (b) racial socialization (r = .19*); and (c) to psychological distress (r = .27**) and anger (Anger-in subscale r = .42**; Hostile Outlook subscale r = .32**).

Main Analyses

To test the first research question stating antecedent variables (i.e., gender, age, SES, and racial composition) and racial socialization would predict racism-related stress, I performed a simultaneous regression. Before I ran the regression, I ran diagnostics to ensure the assumptions of regression were met. Specifically, I checked the normal distribution of variables using skewness and kurtosis statistics, which were discussed previously, as well as homogeneity of variance, which was measured by the tolerance value in the collinearity diagnostics. For all the relevant variables, the tolerance scores were greater than .76 and were greater than 1 - R^2, which indicates that the variables were independent from other variables. Racism-related stress was the criterion variable and survey form, gender, age, SES, racial composition as measured by Harrell's Racial Composition subscale (1997) and racial composition measured by census data, and racial socialization were the predictor variables. The results suggested the overall regression model was statistically significant [F (7, 70) = 3.313, $p < .01$, R^2 = .19] (see Table 3). Findings suggest men, individuals who received messages about race and racism (i.e., racial socialization), and individuals from neighborhoods with fewer Black people reported higher levels of racism-related stress.

Table 3

Simultaneous Regression Analysis Testing Whether Antecedent Variables and Racial Socialization Predict Racism-Related Stress

Variable	*B*	SE *B*	*β*	R^2
Racism-related Stress				
				.19
Form	-.08	.17	-.05	
Gender	-.35	.18	-.22*	
Class	.05	.05	.12	
Age	.01	.01	.19	
Social Influences	.19	.09	.24*	
Racial Composition	.25	.14	.22	
Racial Composition Census	-.01	.00	-.25*	

Note. Social Influences = racial socialization; Racial Composition = racial composition as measured by Harrell subscale (1997); Racial Composition Census = racial composition as measured by the census data.

*$p < .05$

To examine the second and third research questions, I used hierarchical multiple regression to examine whether there was a direct relation between racism-related stress and psychological outcomes and whether racism-related coping and racism-related attitudes moderated the relation between racism-related stress and psychological outcomes. A hierarchical regression analysis was performed in which contextual factors (i.e., survey form, age, gender, class, racial socialization, and racial composition) were entered in the first step. In the second step, DLE and two cultural styles of coping were entered (i.e., Collective and Ritual). Two of the coping styles (Cognitive/Emotional Debriefing and Spiritual-Centered) and racial attitudes (i.e., CoBRAS) were excluded from the analysis because of problems with tolerance and model over specificity. I centered DLE, and ACSI's Collective and Ritual Coping subscales to control for

multicollinearity (Baron & Kenny, 1986; Frazier, Tix, & Barron, 2004). The by-product of DLE and each of the two ACSI coping subscales were entered into the third step of the regression.

In the first regression analysis with psychological distress as the dependent variable, results indicated the overall regression model was statistically significant [F (11, 110) = 3.375, $p < .05$, $R^2 = .19$]. The use of more ritual coping strategies was significantly related to higher levels of psychological distress (see Table 4). The findings suggest two significant two-way interaction terms (racism-related stress and collective coping and racism-related stress and ritual coping). Figure 4 depicts the two-way interaction terms for racism-related stress and collective coping on psychological distress. Figure 5 depicts the two-way interaction terms for racism-related stress and ritual coping on psychological distress. To graph these interactions, I created high and low scores for racism-related stress, collective coping, and ritual coping by subtracting/adding the standard deviation of the sample mean from each individual score (Aiken & West, 1991); thus, high scores represented individuals with scores one standard deviation above the sample mean and low scores represented individuals with scores one standard deviation below the mean. Individuals who reported lower levels of racism-related stress and used higher collective coping strategies to deal with racism-related stress were more likely to report higher levels of psychological distress compared to those who used lower levels of collective coping strategies (see Figure 4). Individuals who reported higher levels of racism-related stress and used higher ritual coping strategies to deal with racism-related stress were more likely to report higher levels of psychological distress compared to those who used lower levels of collective coping strategies (see Figure 5).

Table 4

Hierarchical Multiple Regression Analyses of Contextual Variables, Racism-related Stress, and Cultural Coping Predicting Psychological Distress and Anger

Variable	*B*	SE *B*	*β*	Δ R^2
Psychological Distress				
Step 1				-.03
Form	.01	.18	.00	
Gender	.10	.19	.05	
Class	.09	.05	.17	
Age	-.00	.01	-.02	
Social Influences	.07	.09	.07	
Racial Composition	-.06	.15	-.04	
Step 2				.19
Form	.05	.16	.03	
Gender	.03	.18	.02	
Class	.08	.05	.15	
Age	.01	.01	.07	
Social Influences	.02	.09	.02	
Racial Composition	-.10	.14	-.07	
DLE	.23	.12	.19	
ACSI - Collective Coping	.15	.13	.12	
ACSI - Ritual Coping	.52	.18	.30**	
Step 3				.03
Form	.08	.16	.05	
Gender	.02	.17	.01	
Class	.06	.05	.11	
Age	.00	.01	.03	
Social Influences	-.02	.09	-.03	
Racial Composition	-.15	.14	-.11	
DLE	-4.09	2.12	-3.42	
ACSI - Collective Coping	.06	.14	.05	
ACSI - Ritual Coping	.51	.18	.30*	
DLE X ACSI - Collective Coping	-.43	.20	-3.90*	
DLE X ACSI - Ritual Coping	.50	.24	.34*	
Anger-in				
Step 1				.04
Form	.44	.20	.21*	
Gender	-.18	.21	-.08	
Class	.05	.06	.09	
Age	.01	.01	.12	
Social Influences	.16	.11	.15	
Racial Composition	-.11	.17	-.07	

(continued)

Table 4 (continued)

Variable	*B*	SE *B*	*β*	Δ R^2
Step 2				.07
Form	.49	.19	.24**	
Gender	-.19	.22	-.09	
Class	.04	.06	.07	
Age	.01	.01	.17	
Social Influences	.12	.10	.12	
Racial Composition	-.15	.16	-.10	
DLE	.26	.15	.19	
ACSI - Collective Coping	.13	.16	.09	
ACSI - Ritual Coping	.29	.21	.15	
Step 3				.03
Form	.52	.19	.25**	
Gender	-.20	.21	-.09	
Class	.01	.06	.01	
Age	.01	.01	.12	
Social Influences	.06	.11	.06	
Racial Composition	-.22	.16	-.14	
DLE	-4.74	2.66	-3.40	
ACSI - Collective Coping	.02	.17	.02	
ACSI - Ritual Coping	.25	.21	.13	
DLE X ACSI - Collective Coping	-.50	.26	-3.91	
DLE X ACSI - Ritual Coping	.66	.29	.38*	
Hostile Outlook				
Step 1				.04
Form	.09	.16	.06	
Gender	.10	.16	.06	
Class	.10	.05	.20*	
Age	.00	.01	.02	
Social Influences	.21	.08	.26**	
Racial Composition	-.03	.13	-.02	
Step 2				.04
Form	.12	.15	.07	
Gender	.10	.17	.06	
Class	.08	.05	.17	
Age	.00	.01	.05	
Social Influences	.18	.08	.22*	
Racial Composition	-.07	.13	-.06	
DLE	.18	.11	.16	
ACSI - Collective Coping	.03	.12	.03	
ACSI - Ritual Coping	.23	.18	.14	

(continued)

Table 4 (continued)

Variable	*B*	SE *B*	*β*	Δ R^2
Step 3				-.01
Form	.12	.16	.07	
Gender	.11	.17	.06	
Class	.09	.05	.18	
Age	.00	.01	.07	
Social Influences	.19	.08	.23*	
Racial Composition	-.06	.13	-.05	
DLE	1.69	2.07	1.56	
ACSI - Collective Coping	.06	.13	.05	
ACSI - Ritual Coping	.22	.19	.14	
DLE X ACSI - Collective Coping	.15	.20	1.45	
DLE X ACSI - Ritual Coping	-.08	.26	-.06	

Note. Social Influences = racial socialization; Racial Composition = racial composition as measured by Harrell scale (1997); DLE = Daily Life Experiences Scale; Collective Coping = ACSI's collective coping subscale; Ritual Coping – ACSI's ritual coping subscale.

*$p < .05$, **$p < .01$.

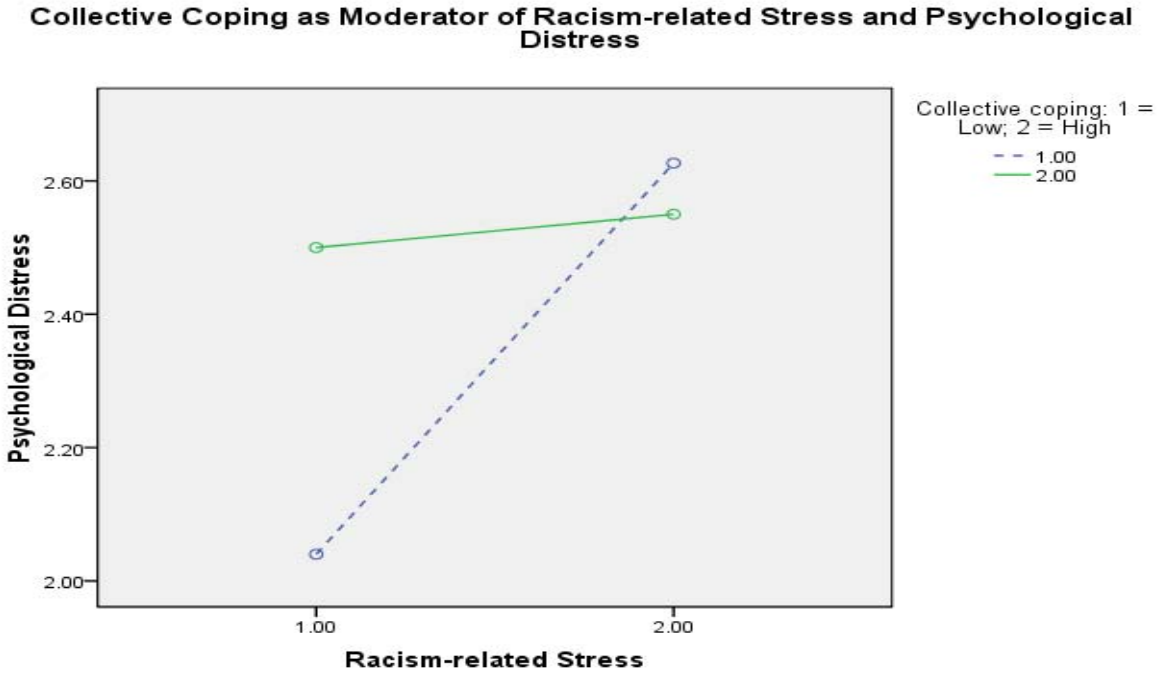

Figure 4. Moderator Effects of Collective Coping on the Relation between Racism-related Stress and Psychological Distress.

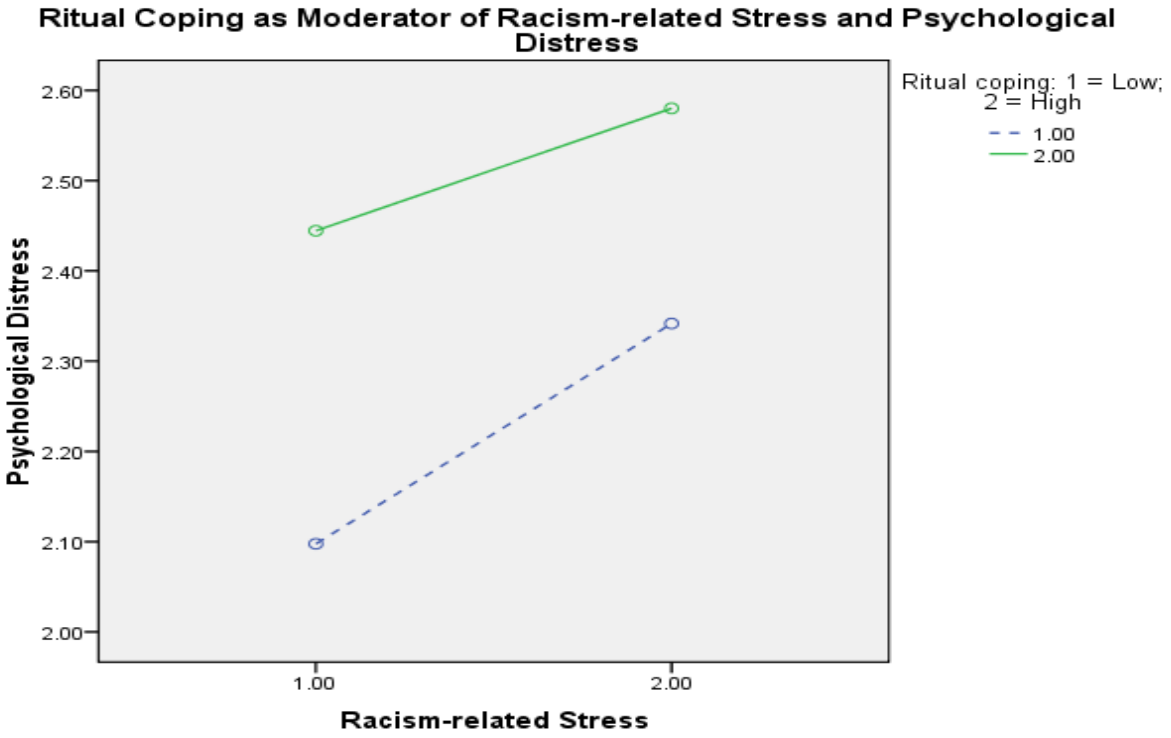

Figure 5. Moderator Effects of Ritual Coping on the Relation between Racism-related Stress and Psychological Distress.

In the second regression analysis with Anger-in as the dependent variable, the overall model was statistically significant [F (11, 105) = 2.653, $p < .05$, $R^2 = .15$]. Individuals who completed the psychological outcomes measures before the racism-related measures scored significantly higher on anger (see Table 4). Moreover, the findings suggest a significant two-way interaction term (racism-related stress and ritual coping). Figure 6 indicates there is an interaction between racism-related stress and ritual coping such that individuals who reported higher levels of racism-related stress and used lower ritual coping strategies to deal with the stress were more likely to report greater levels of anger compared to those who used lower levels of ritual coping (See Figure 6).

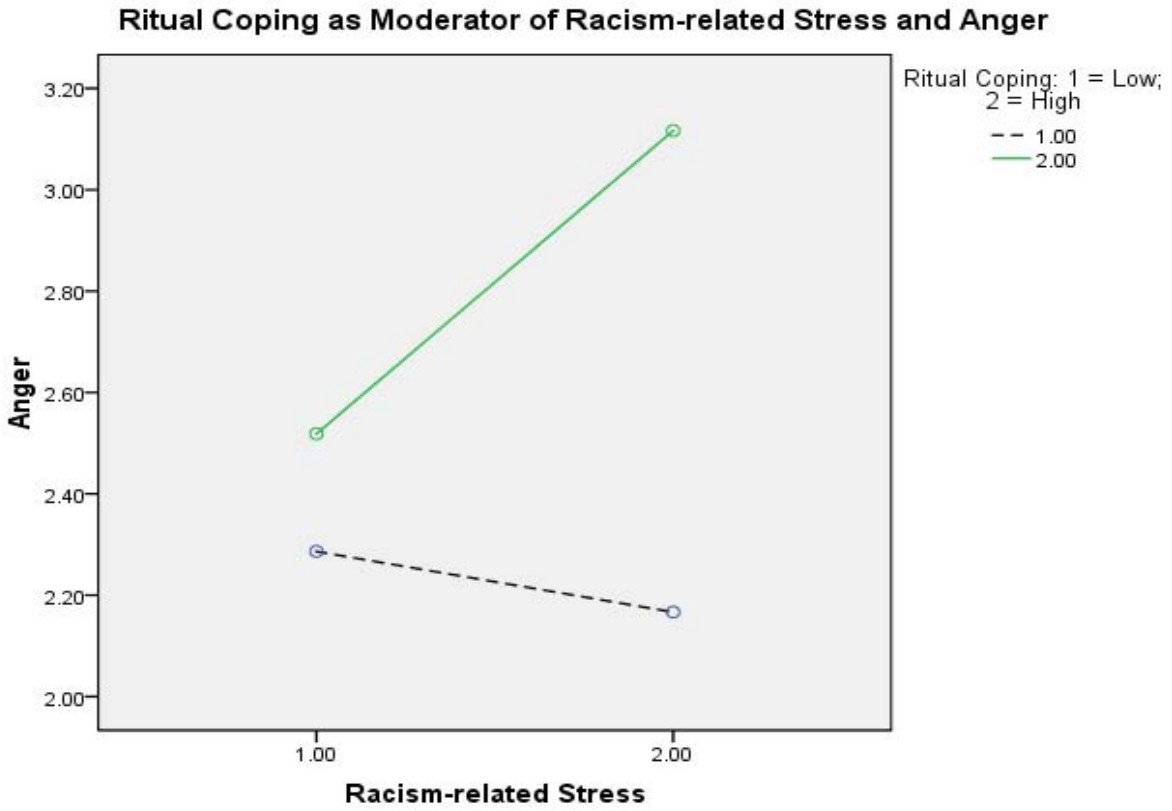

Figure 6. Moderator Effects of Ritual Coping on the Relation between Racism-related Stress and Anger.

In the third regression analysis with hostile outlook as the dependent variable, the overall model was not statistically significant [F (11, 108) = 1.678, p = .08]; however, the second model was [F (9, 108) = 2.019, $p < .05$, R^2 = .07]. Receiving more messages about race and racism (i.e., racial socialization) was significantly related to having more of a hostile outlook on life (see Table 4).

Although DLE was correlated with each of the mental health indicators, DLE did not contribute significantly to any of the regressions. It appears that in this study the relation between perceived-racism stress as measured by the DLE and mental health (i.e., psychological distress, anger, and hostility) was mediated by cultural coping. To test this assumption, I conducted a

series of post-hoc regressions to test if either collective and/or ritual coping strategies mediated the relations between DLE and psychological distress and anger. To examine mediation, the following conditions for the mediation model were examined as outlined by Baron and Kenny (1986): (a) testing whether there was a significant relation between the predictor (i.e., racism-related stress) and outcome variable (i.e., psychological distress and anger); (b) testing whether the predictor was related to the mediator (i.e., collective and ritual coping); (c) testing whether the mediator was related to the outcome variable; and (d) testing whether the strength of the relation between the predictor and the outcome variable was significantly decreased when the mediator was added to the model. Specifically, I examined whether either ritual coping and/or collective coping mediated the relations between racism-related stress and both psychological distress and anger; thus, four mediation models were tested. The two psychological distress mediation models were significant and the two anger models did not meet each condition for mediation (Baron & Kenny, 1986). Specifically, collective coping and ritual coping significantly mediated the association between racism-related stress and psychological distress, such that the strength of the association between racism-related stress and psychological distress significantly decreased when the mediator was added to the model (collective coping: $z = 2.32$, $p < .05$; ritual coping: $z = 3.18$, $p < .05$). Neither of the two anger models met the conditions for mediation. These findings indicate that the relation between racism-related stress and psychological distress was accounted for by an increase in collective and ritual coping strategies.

Chapter Five

Discussion

The purpose of this study was to test an integrated model of racism-related stress. Specifically, in this study I examined the influence of contextual factors (i.e., antecedent variables and racial socialization) on racism-related stress and the subsequent influence this stress had on health outcomes (i.e., psychological distress and anger). Furthermore, I explored whether cultural variables (i.e., cultural coping) moderated and/or mediated this relation among Black Americans. Findings provided partial support for the integrated model. Contextual factors were related to racism-related stress and the relation between racism-related stress and psychological outcomes was both moderated and mediated by cultural coping, although not in the expected direction.

In support of the conceptual model, findings indicated that antecedent variables, particularly gender and neighborhood racial composition, and racial socialization predicted racism-related stress. Specifically, the men in this study and individuals from neighborhoods with fewer Black people reported higher levels of racism-related stress. These findings support previous research that has found gender differences (Broman et al., 2000; Clark, 2004; Fischer & Shaw, 1999; McCord & Ensminger, 1997; Sellers & Shelton, 2003; Utsey et al., 2002), suggesting that men have a greater risk of experiencing racism-related stress. While some researchers attribute this gender difference to Black men receiving harsher treatment because they are the primary targets of discrimination in society due to racist gendered stereotypes (Sellers & Shelton, 2003; Utsey et al., 2002), other researchers attribute this difference to context. Specifically, some researchers found Black men are more likely to report experiencing racism-related stress in terms of job discrimination, discrimination from the police (Broman et

al., 2000), and assumptions related to being a criminal (Fischer & Shaw, 1999) than women. Unfortunately, there is not the same amount of empirical research that has explored the contexts in which women experience racism; therefore, it is difficult to ascertain the specific contexts in which women may experience more racism-related stress. Woods-Giscombe´ and Lobel (2008) suggested little research has been done with women and racism-related stress because of the complex nature of the intersection of race and gender. There is some evidence that Black women experience "gendered racism" (i.e., stress based on the intersection of race and gender) and that the workplace as well as interpersonal relationships are relevant contexts in which Black women experience racism-related stress (Jackson et al., 2001). Furthermore, Fischer and Shaw (1999) suggested "gendered racism" among Black women can influence attributional ambiguity. Particularly, Black women may attribute instances of racism to their gender, instances of sexism to their race, or there may be a combination of the two. As such, in studies like this one that are interested in racism-related stress, Black women may not attribute discriminatory experiences to their race, which would decrease their racism-related stress and make it seem as though Black men experience more racism-related stress. To date, there are no standardized scales examining "gendered racism" for either Black women or Black men. It is also important to note the inherent paradox in the research literature; the lack of empirical research on women and racism-related stress inadvertently perpetuates the idea that Black men receive harsher treatment and are the primary targets of discrimination.

This study also found the racial composition of individual's neighborhood was associated with perceived racism-related stress. Participants who lived in neighborhoods with fewer Black people reported higher levels of racism-related stress. Race may be more salient for these participants because there are not as many people that look like them in their neighborhood and

they may experience more racism which would increase the level of racism-related stress. Harrell (2000) suggested feeling like a "token" (i.e., being numerically in the minority) can increase the stress individual's experience" (p. 50). This suggests living in neighborhoods with more Black people may buffer the impact of racism-related stress perhaps because race is not as salient around other Black people and since racism is based on interracial contact and relationships there are fewer opportunities to experience racism.

Racial socialization also predicted racism-related stress. Findings indicate individuals who received messages about race and racism (i.e., racial socialization) reported higher levels of racism-related stress. This suggests learning about race and racism can exacerbate the level of racism-related stress people experience. This finding is consistent with previous research indicating that racial socialization increased levels of racism-related stress (Bynum et al., 2007). Bynum and colleagues (2007) suggested that receiving messages about race can increase people's knowledge about the harsh reality of racism, which can be psychologically burdensome. A similar pattern has emerged in this sample which could be related to participants' age. The average age of this community sample was 52 years old, which could mean participants had more experience with racism-related stress and/or received more messages about race and racism throughout their life and in more contexts because their experiences were during a time in which overt expressions of racism were more prevalent in society. This indicates racial socialization may be helpful in certain instances but not in others.

The results from this study support some previous research in which specific antecedent variables were not related to racism-related stress (Broman et al., 2000; Clark, 2004; Fisher et al., 2000; Kwate et al., 2003). Similar to other studies, age and class background were not related to racism-related stress. There was variability in the age range of participants and SES was

measured in multiple ways, thus it is unclear why the results in this study duplicated these findings. There was not a clear pattern in the aforementioned studies' assessments of age (i.e., age varied across all studies and ranged from adolescents to the elderly), income (i.e., self-reported measures of SES included education, income, and parents occupation), or racism-related stress. As such, it is difficult to speculate about the meaning of these findings, other than age and class background did not seem to be relevant contextual factors in understanding racism-related stress in this particular sample. Nevertheless, one possible explanation for the findings in this study is that the racial composition of participants' neighborhoods was more important in reporting racism-related stress than SES and age. Race and class are often linked, and since the majority of the sample lived in neighborhoods with a higher percentage of Black people, it is likely that participants came from similar class backgrounds as well. Therefore, racial composition may have confounded the relation between SES and racism-related stress.

This study also found cultural coping was related to psychological outcomes, but not in the expected direction. Specifically, collective coping both mediated and moderated the relation between racism-related stress and psychological distress, such that individuals who reported lower levels of racism-related stress and used greater collective coping strategies to deal with the stress were more likely to report higher levels of psychological distress. In this study, it seems individuals who placed the group above the individual and relied on group-centered activities (i.e., collectivist) reported higher levels of psychological distress, whereas individuals who were more individualistic reported lower levels of psychological distress. These findings are inconsistent with previous research findings suggesting that Black Americans tend to use collectivist coping strategies such as family and community (Daly, Jennings, Beckett, & Leashore, 1995), and these coping strategies are in turn related to positive outcomes such as

higher self-esteem in Black adolescents (Constantine et al., 2002) and quality of life in Black adults (Utsey et al., 2007). On the other hand, two unpublished dissertations found collective coping may be related to psychological distress. Joseph (2006) found collective coping predicted the risk of having clinically significant distress when Black Canadian adults experienced interpersonal discrimination. The researcher suggested this finding could also be interpreted as individuals who have a higher risk for psychological distress prefer to use collective coping strategies to manage the racism-related stress they experience. Joseph also noted that it was difficult to support or interpret the finding based on the extant literature because the study was among the first to examine the effectiveness of cultural coping strategies on managing racism-related stress, let alone provide an interpretation about collective coping strategies. This dilemma is evident in this study as well. The results from this study also suggest that the use of collective coping strategies to manage racism-related stress may be detrimental to individuals' psychological well-being; however it is unclear why this might be the case.

Giscombe (2005) found collective coping did not moderate the relation between stress and psychological distress among Black adult women, and suggested that since collective coping is similar to social support, participants may not have received useful, effective, or healthy advice, which lead to maladaptive coping. This may be a reasonable explanation for the participants in this study as well. When individuals sought support for the racism they encountered, the support may not have been helpful which exacerbated their distress. In contrast, when individuals did not seek support, but perhaps found other ways to cope, they were less distressed. It is unclear why lower levels of racism-related stress was related to greater use of collective coping and higher levels of psychological distress, but may suggest participants are experiencing racism-related stress, but are not acknowledging the stress they experience in this

way. As a result, they still seek social support, but the support they receive is not directed at the real concern, racism-related stress, thus the problem continues and their mental health is negatively impacted. Another explanation could be the way in which racism-related stress and coping were measured. The amount of racism-related stress experienced was measured in the study and not the appraisal of the stress (i.e., the level of stress of the combined incidents); whereas the coping measure was modified to consider strategies used to cope with racism-related stress. It may be that participants who used more coping strategies found the incidents more stressful, irrespective of the combined number of incidents.

Ritual coping, another type of cultural coping, both mediated and moderated the relations between racism-related stress and psychological distress, and moderated the relations between racism-related stress and anger. Individuals who reported higher levels of racism-related stress and used greater ritual coping strategies to deal with the stress were more likely to report greater levels of psychological distress and anger compared to participants who used fewer ritual coping strategies. In this study, it seems individuals who relied on practices aimed at providing guidance and strength have higher levels of psychological distress and anger, whereas individuals who are less likely to cope in this way have lower levels of psychological distress and anger. Similar to the aforementioned collective coping finding, these results were unexpected. Unfortunately, unlike with the collective coping subscale, there were no other studies that examined the implications of the ritual subscale. Instead, studies focused on the spiritual-centered subscale.

Although these two scales are similar, they are conceptually different in that the spiritual subscale assesses individuals' connection with a higher power and has more of a religious/spiritual focus, whereas the ritual subscale is more general in nature and focuses on strength and guidance. Even though other studies have not provided interpretations for the ritual

subscale, a possible explanation for the results in this study is ritual coping seems to be a more emotion-focused type of coping which in the past has been found to not be as helpful in dealing with stress in general (Armstead et al., 1989; Utsey, Ponterotto, et al., 2000). For example, some of the items deal with actions to ease one's discomfort as opposed to approach the problem directly (e.g., "Lit a candle for strength or guidance in dealing with the problems"). Therefore, participants' use of ritual coping to manage racism-related may not have been effective, which lead to increased levels of anger.

Another interpretation might be that participants were asked about instances of racism in which they felt angry. Previous research suggests anger is a common psychosocial response after individuals experience racism (Bullock & Houston, 1987); therefore, asking participants about their anger in regards to a racist event may have primed and heightened their level of anger, which would be reflected in their responses (i.e., higher levels of anger). In this way, the finding is consistent with previous research in that participants respond to racism-related stress with increased levels of anger. Unfortunately, this anger was not effectively managed with ritual coping in this sample.

The cultural coping findings collectively may be related to the ways in which the construct was measured in this study. Unlike previous research, in this study, I asked participants to first think about a racism-related incident that occurred within the last year and to report how much they engaged in the specific coping strategy to specifically deal with racism or discrimination more generally. It may be that this primed individuals to think of a distressing racist event that may have been unresolved and that they were still trying to cope with. As such, the coping strategies may not have been useful in dealing with that particular racist event, but may be useful under different circumstances. It could be that if participants were asked about

cultural coping in general as opposed to in a specific situation, the findings may have been different and would have supported previous research.

There are other possible explanations for these results as well. Similar to Joseph's (2006) interpretation, another possible explanation for these findings are that individuals who are more distressed have a specific coping pattern, in which they try to manage their distress with various coping strategies, but are unsuccessful. Individuals may be unsuccessful and remain distressed because racism is a pervasive stressor that is unlike other stressors they have to manage. Racism does not exist solely on an individual level, because it is systemic (e.g., institutional, environmental); therefore, racism is difficult to control which decreases individuals sense of agency. As such, individuals use more cultural coping strategies because they are trying to increase their psychological well-being; however, these attempts are more focused on improving their mood than effectively changing the problem (i.e., racism). They remain distressed because racism persists.

Other explanations might also be related to the sample in this study. First, it is important to note the difficulty in comparing samples from studies, because researchers provide different sociodemographic information. Nevertheless, based on comparisons with other studies, this study has distinct sociodemographic characteristics including the age (i.e., older sample), percentage of women (i.e., more women), educational background (i.e., high education status), religious affiliation (i.e., Christian), and salience of religion (i.e., very religious). The sample for this study is most similar to Giscombe's (2005) study in terms of age, educational background, and employment status (majority employed full-time). Giscombe's findings were also similar to the findings in this study in that she found collective coping did not moderate the relation between stress and psychological distress. On the other hand, the studies whose findings were

not similar to this study are characterized by younger samples (mostly college students), a more balanced gender ratio, or studies with little sociodemographic information.

Additionally, given the sample reported a higher level of educational attainment, educational background may be a more relevant coping mechanism for racism-related stress than cultural coping strategies. Specifically, higher educational status was related to decreased levels of racial color-blind ideology and decreased psychological distress. It could be that education is a more effective coping strategy than cultural coping because through school, participants may have learned about the pervasiveness of racism and have learned to externalize racism to systemic factors, as opposed to internalize racism. Therefore, they have lower levels of psychological distress. Another explanation related to the sample of the participants might be participants' racial identity. Racial identity was not assessed in the study, but it could be that participants are in a more African-centered stage of racial identity, such as the immersion stage, and are very aware of racism. Due to this awareness, they experience more racism-related stress, which is difficult to manage because racism is so prevalent.

Racial socialization messages in this study were also significantly related to having an increased hostile outlook on life. In this study, I hypothesized that increased messages about race and racism would be related to racism-related stress, but was not expecting a relation between racial socialization and anger. Nevertheless, this finding is consistent with some research findings indicating a relation between racial socialization and anger (Hughes et al., 2006). For example, Stevenson and colleagues (1997) found racial socialization messages that encouraged cultural pride are related to negative anger expression in girls. The researchers attributed this finding to parents' overemphasis on racism. It is possible that a similar phenomenon occurred in

this sample and once individuals become aware of racial inequality they become angry about the unfairness of life and the struggles they might experience because they are Black.

Similar to the observations about the relations between racial socialization and racism-related stress, at this point it is unclear what racial socialization may mean for an adult community sample. Most studies on racial socialization focus on youth and/or emerging adults that are in school. The developmental tasks of younger populations in understanding and negotiating racism are very different than a middle-aged sample. As mentioned previously, it could be that older individuals have higher levels of racism-related stress and racial socialization because they grew up during the Civil Rights Movement. These experiences may have increased participants anger because they are more aware and have more experience with racism.

Racism-related stress was not related to racial attitudes (i.e., CBRI). In fact, CBRI as measured by the CoBRAS was not included in the final regression model because of issues associated with multicollinearity and model specificity. Moreover, unlike previous published studies, in this study I obtained a lower than ideal Cronbach's alpha for the total score. Previous studies with Black adults used the full 20-item CoBRAS, but in this study I used the shorter 14-item CoBRAS. More information is needed about the reliability of the CoBRAS with older Black samples using the short versus the full scale. Future researchers could also identify other potential racial attitudes to assess as moderators such as internalized and cultural racism.

Limitations and Future Research Suggestions

Although this study provided partial empirical support for the integrated model of racism-related stress, there are a number of noteworthy limitations. First, there is some variability in the sample because the data were collected in the Midwest and South; however, there may have been

unique attributes about the sample that do not represent other regions of the country (i.e., East/West Coast). For example, the majority of the sample voted Democrat in the last election and identified as Christian. Future researchers should expand their study across the country and have more variability in people's preferences because it is important to understand how racism-related stress influences the health of a variety of people. It would be interesting to see if there were differences between participants racism-related stress on the East Coast versus the West Coast.

Although I used census data to examine the racial and class composition of participants' neighborhoods, a number of people did not provide the necessary information to retrieve these data. Thus, the census data could not be included in the main regression analyses testing the effects on psychological outcomes. Moreover, the study relied on self-report data, which can produce biased results. Problems with self-report data include recall (e.g., accuracy and bias) and the potential for participants to exaggerate or minimize their experience. For example, time may be an important factor in terms of the extent to which an individual is affected by racism. Participants may have greater levels of psychological distress and anger about recent events of racism, because these experiences are salient; whereas participants may have more perspective about past experiences of racism, thus their psychological distress and anger may not be as significant and harmful to their psychological well being. In this study, participants were asked to think about times in which they experienced racism in the last year, but it is unclear whether they thought of a recent event (i.e., last week or month) or an event that was not as recent (i.e., six months or a year ago). Scores on the racism-related stress scale indicated on average participants experienced racism a couple times a year, so it may be the case that on average participants thought about past events of racism, thus they were not as salient and may have been

minimized. Using other methods to collect data such as experiments and observations may provide richer and more accurate assessments of participant's experiences over self-report.

Another limitation is in each of the models, a significant amount of variance remained unaccounted. Future researchers should identify additional conceptually driven factors that may help explain the outcome variables including skin tone, geographic location, family roles, worldview, social support, physiological response to stress. Additionally, future studies should use more sophisticated analyses to explore the relation between racism-related stress and health, such as using structural equation modeling (SEM).

Implications

There are implications from the results of this study. Cultural coping, specifically collective and ritual coping strategies, moderated the relation between racism-related stress and psychological outcomes which suggests using certain cultural coping strategies may exacerbate an individual's distress if the support they received was not helpful or if the racism-related was too severe for the cultural coping strategies to be effective. Therefore, it is important for Black Americans to find ways to cope that actually decrease their distress, not exacerbate it. Using general ways to cope such as encouraging the use of problem-focused coping (e.g., challenging racial discrimination) may be helpful in ameliorating the negative effects of racism-related stress. This technique is effective because it is concrete, proactive, and encourages change for difficult situations. It does not seem the use of cultural coping is helpful in managing racism-related stress in this sample, thus Black Americans should refrain from this form of coping, particularly if it leads to more negative outcomes.

Moreover, there is a need for psychoeducation about the existence of racism, the impact it has on an individual's health, and how to cope with racism, because it could be the case that Black Americans do not attribute the stress they experience to race, which means they are unable to properly manage the stress. Furthermore, because the racism-related stress Black Americans experience negatively influences their health, these individuals may seek counseling services to address these issues. Therefore, it is essential for psychologists to not only recognize the existence of racism, but to also be sensitive to how racism may influence Black Americans psychological health as well as to be aware of the aforementioned effective and maladaptive coping strategies Black Americans may use to manage racism-related stress. In particular, counselors should be aware of demographic variables that increase the likelihood of individuals experiencing racism-related stress, such as the antecedent variables (e.g., gender and racial composition), and racial socialization found in this study. It is important that counselors explore the various contexts that racism may occur and recognize that the resulting racism-related stress impacts people differently. For Black men, it is important for counselors to recognize that they may feel like they are the primary targets of racism, and that they experience racism particularly in employment, the police, and being assumed they are a criminal. For Black women, it is important for counselors to recognize the racism and sexism Black women experience, and that they experience racism particularly in employment and interpersonal relationships. In either case, it is imperative that counselors validate their clients' experiences of racism and work to help them cope across a variety of domains. Counselors should also work with Black Americans who are in predominantly White environments to identify effective strategies to cope with racism, because there is a greater risk they will experience racism-related stress. Furthermore, counselors should be aware of how Black Americans are being or have been socialized about race and

racism to ensure this is not exacerbating clients distress. While it is important for Black Americans to be aware of race and racism, having this knowledge without the appropriate skills to cope with this awareness could be harmful.

Counselors should also be aware that Black Americans may have a more hostile outlook on life because they have been socialized to be aware of the injustice they may experience. Moreover, counselors should be cognizant of the type of coping strategies their clients may use in different contexts, because their clients psychological well-being can vary depending on the coping strategy. As mentioned previously, it is important that clients recognize the racism they experience and are aware of multiple ways to cope with racism-related stress in different situations, and that counselors are able to explore these possibilities with clients.

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Appendix A

Participant Information Letter

SOCIAL ATTITUDES SURVEY

You are being invited to participate in a study entitled "Testing an Integrated Model of Perceived Racism among Black Americans" directed by Alexis Clarke, M.S., a doctoral student at the University of Illinois at Urbana-Champaign and that is supervised by Dr. Helen A. Neville of the Department of Educational Psychology and African American Studies at the University of Illinois at Urbana-Champaign. Ms. Clarke and a small number of trained research assistants will assist Dr. Neville in data collection and analyses. The purpose of the study is to learn about your experience and how you think about different social problems. Your participation will consist of completing a relatively brief questionnaire around topics such as your daily life experiences (e.g., "Being stared at by strangers."), the way you deal with stress (e.g., "Got dressed up in my best clothing."), and your opinion on social issues (e.g., "Racism may have been a problem in the past, but it is not an important problem today.").

Your participation in this project is completely voluntary. You will not suffer any negative consequences if you decide not to participate. You also have the right to stop participating at any time. Your participation is not expected to cause any harm outside of what is normally encountered in daily life. However, if you do become upset while completing the survey, you can talk to Ms. Clarke or Dr. Helen Neville directly after taking the survey. You can also contact one of the organizations on the resource list for additional help or more information about this topic.

Your participation in the survey is designed to be completely anonymous, because you will **not** be giving your name or other identifying information anywhere on the survey.

The results from this study may be published in a professional journal or in a government grant application, but you will not be identified as an individual as you will not be providing any identifying information. Instead, results will be reported as group averages. If you would like a summary of the research when it is complete, you can contact the researchers using the information provided at the bottom of this page.

As a token of appreciation, you will be able to choose between a beverage, candy, or bag of potato chips. Also, your participation will help provide important information that could influence the development of prevention and intervention programs.

If you have any questions or concerns about participation in this research, you can contact Alexis Clarke by e-mail (clarke@uiuc.edu) or Dr. Helen Neville by phone (217-244-1691) or email (hneville@uiuc.edu). For any questions about your rights as a research participant, please feel free to contact the Bureau of Educational Research in the College of Education at 217-333-3023 or via e-mail at ber@ed.uiuc.edu or the University of Illinois Institutional Review Board (IRB) at

217-333-2670 or via e-mail at irb@uiuc.edu. The IRB can also be called collect if you identify yourself as a study participant.

If I choose to participate, I affirm that I am 18 years old or older and that I can provide consent to participate.

Please keep a copy of this information letter for your records.

. **Appendix B**

Survey

Code Number

A

SOCIAL ATTITUDES SURVEY

PRINCIPAL INVESTIGATORS

Helen Neville, Ph.D. hneville@uiuc.edu

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Department of Educational Psychology
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THE SURVEY IS DOUBLE-SIDED

PLEASE TURN TO NEXT PAGE

SOCIAL ATTITUDES SURVEY

Directions. Below is a set of questions that deal with social issues in the United States (U.S.). Using the **6-point scale** below, please give your honest rating about the degree to which you personally agree or disagree with each statement. Please be as open and honest as you can; there are no right or wrong answers. Please circle the appropriate number corresponding to your response.

	Strongly Disagree					Strongly Agree
1. Everyone who works hard, no matter what race they are, has an equal chance to become rich.	1	2	3	4	5	6
2. Race plays a major role in the type of social services (such as type of health care or day care) that people receive in the U.S.	1	2	3	4	5	6
3. It is important that people begin to think of themselves as American and not African American, Mexican American or Italian American.	1	2	3	4	5	6
4. Racism may have been a problem in the past, but it is not an important problem today.	1	2	3	4	5	6
5. Racial and ethnic minorities do not have the same opportunities as White people in the U.S.	1	2	3	4	5	6
6. White people in the U.S. are discriminated against because of the color of their skin.	1	2	3	4	5	6
7. White people in the U.S. have certain advantages because of the color of their skin.	1	2	3	4	5	6
8. Immigrants should try to fit into the culture and adopt the values of the U.S.	1	2	3	4	5	6
9. White people are more to blame for racial discrimination in the U.S. than racial and ethnic minorities.	1	2	3	4	5	6
10. Social policies, such as affirmative action, discriminate unfairly against White people.	1	2	3	4	5	6
11. It is important for public schools to teach about the history and contributions of racial and ethnic minorities.	1	2	3	4	5	6
12. Racial and ethnic minorities in the U.S. have certain advantages because of the color of their skin.	1	2	3	4	5	6
13. Racial problems in the U.S. are rare, isolated situations.	1	2	3	4	5	6
14. Race plays an important role in who gets sent to prison.	1	2	3	4	5	6

THE SURVEY IS DOUBLE-SIDED

PLEASE TURN TO NEXT PAGE

Directions. These questions ask you to think about experiences that some people have as they go about their daily lives. Using the **6-point scale**, please determine how often you have each experience because of your race or racism.

	Never	Less Than Once a Year	A Few Times a Year	About Once a Month	A Few Times a Month	Once a Week or More
1. Being ignored, overlooked, or not given service (in a restaurant, store, etc.).	0	1	2	3	4	5
2. Being treated rudely or disrespectfully.	0	1	2	3	4	5
3. Being accused of something or treated suspiciously.	0	1	2	3	4	5
4. Others reacting to you as if they were afraid or intimidated.	0	1	2	3	4	5
5. Being observed or followed while in public places.	0	1	2	3	4	5
6. Being treated as if you were "stupid", being "talked down to."	0	1	2	3	4	5
7. Your ideas or opinions being minimized, ignored, or devalued.	0	1	2	3	4	5
8. Overhearing or being told an offensive joke or comment.	0	1	2	3	4	5
9. Being insulted, called a name, or harassed.	0	1	2	3	4	5
10. Others expecting your work to be inferior.	0	1	2	3	4	5
11. Not being taken seriously.	0	1	2	3	4	5
12. Being left out of conversations or activities.	0	1	2	3	4	5
13. Being treated in an "overly" friendly or superficial way.	0	1	2	3	4	5
14. Being avoided, others moving away from you physically.	0	1	2	3	4	5
15. Being mistaken for someone who serves others (i.e., janitor, bellboy, maid).	0	1	2	3	4	5
16. Being stared at by strangers.	0	1	2	3	4	5
17. Being laughed at, made fun of, or taunted.	0	1	2	3	4	5
18. Being mistaken for someone else of your same race (who may not look like you at all).	0	1	2	3	4	5

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

	Never	Less Than Once a Year	A Few Times a Year	About Once a Month	A Few Times a Month	Once a Week or More
19. Being asked to speak for or represent your entire racial/ethnic group (e.g., "What do _____ people think"?).	0	1	2	3	4	5
20. Being considered fascinating or exotic by others.	0	1	2	3	4	5

Directions. Please answer the following questions.

1. As you were growing up, how much were things related to race or racism talked about by the people or in the settings listed below? Please circle the appropriate number.

	Not at All	A Little	Some	A Lot	Extremely So
a) Your parents	0	1	2	3	4
b) Other family	0	1	2	3	4
c) Your friends	0	1	2	3	4
d) Your teachers	0	1	2	3	4
e) At your place of worship	0	1	2	3	4

2. **Directions.** Use the scale below to indicate the racial composition of each of the categories listed. Write the appropriate number on each of the blank lines.

0 = Does Not Apply to Me
1 = Entirely People of My Race
2 = Mostly People of My Race (A Few People from Other Races)
3 = Racially Integrated to a Large Degree
4 = Mostly People of Different Racial/Ethnic Minority Groups than Mine
5 = Mostly or Entirely White (No Not Use This Response if You are White)

_____ a) your neighborhood growing up
_____ b) your current neighborhood
_____ c) your current job
_____ d) your elementary & jr. high schools
_____ e) your high school
_____ f) your place of worship growing up
_____ g) your place of worship now
_____ h) your close friends growing up
_____ i) your close friends now
_____ j) your intimate relationships

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

Directions. The statements below are intended to represent some of the ways people cope with stressful situations in their daily lives. In order to respond to the statements below you will need to think of a specific stressful situation that you may have encountered THAT SPECIFICALLY RELATES TO RACE. Think about a "stressful situation" related to race that you found troubling or otherwise caused you to worry. Such race related stressful situations might have been related to your family, friends, school, job, romantic relationship, or other things you consider important in your life. If you have never experienced a stressful situation related to race, please write about a stressful situation related to another social identity like gender, class, etc.

To help us better understand the exact nature of the stressful situation you are thinking of when responding to the statements in this questionnaire, please take a moment to write a brief description of the situation in the space provided below.

Use this space to describe your stressful situation; describe the setting, what happened, who was involved, how the situation made you feel

DID YOU REMEMBER TO DESCRIBE YOUR STRESSFUL SITUATION?

Now, keeping in mind the (race related) situation you just described in the previous page and similar situations, please indicate the extent to which you used each of the strategies described on the following pages to help you cope with the stress you experienced.

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

	Does Not Apply or Did Not Use	Used a Little	1	Used a Lot	Used a Great Deal
1. Prayed that things would work themselves out.	0	1		2	3
2. Got a group of family or friends together to help with the problem.	0	1		2	3
3. Shared my feelings with a friend or family member.	0	1		2	3
4. Remembered what a parent (or other relative) once said about dealing with these kinds of situations.	0	1		2	3
5. Tried to forget about the situation.	0	1		2	3
6. Went to church (or other religious meeting) to get help from the group.	0	1		2	3
7. Thought of all the struggles Black people have had to endure and this gave me strength to deal with the situation.	0	1		2	3
8. To keep from thinking about the situation I found other things to keep me busy.	0	1		2	3
9. Sought advice about how to handle the situation from an older person in my family or community.	0	1		2	3
10. Read a scripture from the Bible (or similar book) for comfort and/or guidance.	0	1		2	3
11. Asked for suggestions on how to deal with the situation during a meeting of my organization or club.	0	1		2	3
12. Tried to convince myself that it wasn't that bad.	0	1		2	3
13. Asked someone to pray for me.	0	1		2	3
14. Spent more time than usual doing group activities.	0	1		2	3
15. Hoped that things would get better with time.	0	1		2	3
16. Read passage from a daily meditation book.	0	1		2	3
17. Spent more time than usual doing things with friends and family.	0	1		2	3
18. Tried to remove myself from the situation.	0	1		2	3
19. Sought out people I thought would make me laugh.	0	1		2	3
20. Got dressed up in my best clothing.	0	1		2	3
21. Asked for blessings from a spiritual or religious person.	0	1		2	3
22. Helped others with their problems.	0	1		2	3
23. Lit a candle for strength or guidance in dealing with the problem.	0	1		2	3
	Does Not Apply or Did Not Use	**Used a Little**	**2**	**Used a Lot**	**Used a Great Deal**
24. Sought emotional support from family and friends.	0	1		2	3

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

26. Attended a social event (dance, party, movie) to reduce stress caused by the situation.	0	1	2	3
27. Sung a song to myself to help reduce the stress.	0	1	2	3
28. Used a cross or other object for its special powers in dealing with the problem.	0	1	2	3
29. Found myself watching more comedy shows on TV.	0	1	2	3
30. Left matters in God's hands.	0	1	2	3

Directions. Using the **6-point scale**, please indicate how much of the time you felt in the specified way during the past month; please circle the appropriate number corresponding to your response.

How much of the time, during the past month, have you...	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little More of the Time	None of the Time
1. Been a very nervous person.	1	2	3	4	5	6
2. Felt calm and peaceful.	1	2	3	4	5	6
3. Felt downhearted and blue.	1	2	3	4	5	6
4. Been a happy person.	1	2	3	4	5	6
5. Felt so down in the dumps that nothing could cheer you up.	1	2	3	4	5	6

Directions. - Everybody gets angry from time to time. A number of statements that people have used to describe the times that they get angry are included below. Using the **5-point scale** below, read each statement and circle the number to the right of the statement that best describes you. There are no right or wrong answers. Please answer every item.

	Completely Undescriptive	Mostly Undescriptive	Partly Undescriptive	Mostly Descriptive	Completely Descriptive
1. I have met people who are supposed to be experts who are no better than I.	1	2	3	4	5
2. Some of my friends have habits that annoy and bother me very much.	1	2	3	4	5
3. At times, I feel angry for no specific reason.	1	2	3	4	5
4. I can make myself angry about something in the past just by thinking about it.	1	2	3	4	5

	Completely Undescriptive	Mostly Undescriptive	Partly Undescriptive	Mostly Descriptive	Completely Descriptive
5. People can bother me just by being around.	1	2	3	4	5
6. When I get angry, I stay angry for hours.	1	2	3	4	5
7. I am on my guard with people who are	1	2	3	4	5

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

friendlier than I expected.					
8. I get angry when someone lets me down.	1	2	3	4	5
9. I get angry when people are unfair.	1	2	3	4	5
10. I get angry when I have to take orders from someone less capable than I.	1	2	3	4	5
11. I get angry when I have to work with incompetent people.	1	2	3	4	5
12. I get angry when I am not given credit for something I have done.	1	2	3	4	5
Thinking about a time in which you experienced racism, please respond to the following items:					
13. I harbor grudges that I don't tell anyone about.	1	2	3	4	5
14. I try to get even when I am angry with someone.	1	2	3	4	5
15. I feel guilty about expressing my anger.	1	2	3	4	5
16. Even after I have expressed my anger, I have trouble forgetting about it.	1	2	3	4	5
17. When I hide my anger from others, I think about it for a long time.	1	2	3	4	5
18. If I let people see the way I feel, I'd be considered person to get along with.	1	2	3	4	5

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

Directions. Please tell us about yourself by filling in or circling the following information as completely as possible.

1. Age: _____

2. Gender:
_____ Male _____ Female

3. What is your racial group (e.g., Black, Latino, White, Asian)?
_____

4. What is your ethnic group (e.g., African American, Mexican, Italian, Chinese)?

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5. What's the highest level of education you have completed?

a. Elementary school (8th grade)
b. Some high school
c. High school diploma or equivalent
d. Some college
e. Associate or two-year degree
f. Bachelor's or four-year degree
g. Some graduate or professional school
h. Business or trade school
i. Graduate or professional degree

6. Currently, how religious or spiritual are you?

a. Not at all religious/spiritual
b. A little religious/spiritual
c. Somewhat religious/spiritual
d. Very religious/spiritual

7. Which religion or spiritual beliefs do you identify with?

a. Christian/Catholic
b. Protestant
c. Muslim
d. Hindu
e. Jewish
f. Buddhism
g. Agnostic or Atheist
h. Other (Specify_____)

8. What political party did you most strongly identify with in the recent election?

a. Democrat
b. Republican
c. Green
d. Independent
e. Other (Specify) _____

9. What is your current occupation?

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

10. Are you employed:

____Full-time ____Part-time ____Unemployed

11. How would you describe your current physical health?

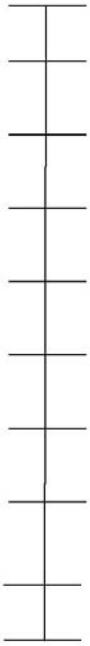
Very Poor Poor Fair Good Very Good

12. How would you describe your current mental health?

Very Poor Poor Fair Good Very Good

13. Think of this ladder as representing where people stand in our society. At the top of the ladder are the people who are the best off – those who have the most money, most education and best jobs. At the bottom are the people who are the worst off – who have the least money, least education, and the worst jobs or no jobs. The higher up you are on this ladder, the closer you are to the people at the very top and the lower you are, the closer you are to the people at the very bottom. Please mark an "X" on the rung on the ladder where you would place yourself; you can mark the "X" anywhere on the line below that best describes your current social position

PEOPLE WHO ARE THE BEST OFF



PEOPLE WHO ARE THE WORST OFF

THE SURVEY IS DOUBLE-SIDED **PLEASE TURN TO NEXT PAGE**

Code Number: _____

14. What is your current address AND/OR the closest cross streets to your home, including city/state, zip code, and how long you have lived at this address? **PLEASE NOTE WE WILL DETACH THIS SHEET FROM THE REST OF THE SURVEY.**

Street Address:

_____

City/State:

_____

Zip Code:

_____

How long have you lived at this address? _____ years _____ month

THANK YOU FOR YOUR TIME AND PARTICIPATION!